Policy and Program Initiatives
On Adolescent Reproductive Health in Sub-Saharan Africa:
What has been done since Cairo?

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List of Acronyms

AAS	Association for African Solidarity
ABBEF	Association Burkinabé pour le Bien-être Familial
AIDS	Acquired Immune Deficiency Syndrome
APEJAD	Association pour la Promotion de la Jeunesse Africaine pour le Développement
APES	Amicale pour la Promotion de l'Equilibre Social
ALVF	Association de Lutte contre les Violences faites aux Femmes
ARC EN CIEL	Association Culturelle de Promotion et de Protection des Droits de l'Enfant et d'Éducation au Développement
ARH	Adolescent Reproductive Health
ATBEF	Association Togolaise pour le Bien-Être Familial
CFJA	Centre de Formation des Jeunes Agriculteurs
CAMNAFAW	Cameroonian Association Family Well Being
CASS	Centre d'Animation Sociale et Sanitaire
CIDA	Canadian International Development Agency
CNLS	Comité National de Lutte contre le SIDA
CSA	Association Camerounaise pour la Santé des Adolescents
DPNP	Déclaration de Politiques Nationale de Population
DSF	Division de la Santé Familiale
EPD	Education en matière de Population et d'Environnement pour le Développement Durable
EmP/EVF	Education en matière de Population/Education à la Vie Familiale
FESADE	Femmes-Santé-Développement en Afrique Sub-Saharienne
FGM	Female Genital Mutilation
FLE	Family Life Education
FP	Family Planning
FPIA	Family Planning International Assistance
GTZ	German Cooperation Agency

IAAH	International Association for Adolescent Health
ICPD	International Conference on Population and Development
IEC	Information Education and Communication
IFORD	Institut de Formation et de Recherche Démographique
IPC	Initiative Privée Communautaire de Lutte contre le Sida
IPPF	International Planned Parenthood
IRESCO	Institut de Recherche et des Etudes de Comportements
MCH/FP	Maternal and Child Health/Family Planning
NGO	Non-governmental Organization
NPP	National Population Policies
OCCGE	Organisation de Coopération Contre les Grandes Endémies
OFSAD	Organisation des Femmes pour la Sécurité Alimentaire et le Développement
PANEM	Prgramme d'Action National pour Eliminer les Mutilations génitales féminines
PNLS	Programme National de Lutte contre le SIDA
PMSC	Programme de Marketing Social au Cameroun
PPLS	Projet Population et Lutte contre le SIDA
RENAJEP	Réseau National de la Jeunesse pour la Promotion de la Santé Sexuelle et Reproductive
ROSACAM	Réseau des Organisations de Santé au Cameroun
SCS	Service Catholique de Santé
STD	Sexually Transmitted Disease
UNICEF	United Nation Children's Fund
UERD	Unité d'Enseignement et de Recherche en Démographie
URD	Unité de Recherche Démographique
USAID	United States Agency for International Development
UNFPA	United Nations Population Fund
WHO	World Health Organization
YDF	Youth Development Foundation

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I. INTRODUCTION

At the International Conference on Population and Development (ICPD) held in Cairo in 1994, more than 180 countries of which 38 were sub-Saharan African countries, signed a historic agreement committing themselves to a Program of Action that includes providing sexual and reproductive health education, information and services to adolescents (United Nation 1994). Four years after the Cairo conference, the purpose of the present study is to assess the status of policy and programs affecting the reproductive health (RH) of adolescents and to evaluate the progress made in implementing the ICPD agenda in the area of adolescent reproductive health in three sub-Saharan African countries.

Addressing adolescent reproductive health (ARH) issues is particularly crucial in sub-Saharan Africa. First, the region has the world's highest rate of early childbearing. More than 50 percent of African women, especially those in West Africa, marry and bear their first child before age 20 (United Nations 1995). This practice carries with it important health consequences. Women who begin their fertility careers in their adolescent years face increased risks to their health and that of their children. Maternal mortality and pregnancy-related complications occur disproportionately at early ages and children born to very young mothers are at higher risks of premature birth, low birth weight, and mortality. While early first marriage and early sexual initiation and childbearing is nothing new in the region, what is new is the increasing number of adolescents who become sexually active and bear children prior to marriage, especially in urban area and among educated youth (Bledsoe and Cohen 1993). This trend toward later marriage and premarital sexual activity has increased the risks of unwanted pregnancy, and induced abortion.

Pregnancy to unmarried adolescents, especially those who are in school, is often perceived as a social disaster, and without surprise, abortion rates are believed to be rising in sub-Saharan Africa especially among schoolgirls (Coeytaux 1988; United Nations 1995). Abortions are particularly dangerous to adolescent women because they are more likely to resort to unsafe and self-induced abortion and to postpone abortion longer compared to older women, given the fact that the practice is largely illegal in most of the countries in the region (Friedman 1994). Sexual activity of unmarried youth is also closely associated with sexually transmitted diseases (STDs), including AIDS. Africa has the highest HIV rate in the world. AIDS studies in three African and two Asian countries estimate that women aged 15 through 25 years account for 70 percent of the 3,000 women who contract HIV every day in the world and of the 500 who die from it (Reid and Bailey 1993). Finally, the deteriorating economic conditions that characterized most African countries have also placed young people, especially young women, at increased risk of abusive, exploitative, and unsafe sexual encounters (Meekers and Calvès 1997; McCauley et al. 1995).

Although it is clear that services and information are required to meet adolescents' reproductive health needs, adolescents still have limited access to such services and information (Friedman, 1994). In most African countries, youth's knowledge about reproduction and sexuality remains low and inaccurate knowledge about sexual issues abounds (Senderowitz 1995). Family planning service programs still emphasize service to older, married women who have completed their childbearing or who wish to determine the spacing and timing of the future births (Senderowitz 1997a). Even when there is no legal or policy restrictions to serving youth, adolescents and young adults are reluctant to use public facilities because of lack of privacy and confidentiality, as well as a judgmental and unsympathetic reception that they think they will receive (CERPOD 1996). In fact, providing sexual education to adolescents in this modern era has always been a very controversial issue in the region, though there were mechanisms for doing so in the traditional societies (Bledsoe and Cohen 1993). Although research overwhelmingly points to the contrary, parents, teachers and politicians often believe that sex education and the availability of family planning services for adolescents will increase young people's interest and involvement in sexual activity (Birdthistle and Vince-Whitman 1997).

Today, the concept of adolescent reproductive health is still new and controversial in sub-Saharan Africa, and there is often an important gap between the declarations and resolutions taken by policy-makers and government officials and the actual design of reproductive health policies and programs geared toward youth. Despite the official commitment of African policy-makers, addressing the reproductive health needs of adolescents as a group remains one of the major public policy issues in the region today.

In such a context, research that reviews and evaluates the status of youth-related reproductive health policies and programs, is strongly needed to set the benchmarks against which future policy and program development and action will be measured. This is the purpose of the present study.

The present report is organized in five sections. The first section presents the goals and specific objectives of the study. Section two describes the study design and presents the study settings, the definitions, and conceptual framework guiding the analysis. The data sources and data analysis are then described. The presentation of the results are shown in section four and the conclusions are presented in the last section of the report.

II. GOALS AND OBJECTIVES OF THE STUDY

The primary goal of the study is to evaluate the current status of policies and programs affecting adolescent sexual and reproductive health in Burkina Faso, Togo, and Cameroon and to assess the progress made in each country in implementing the 1994 ICPD Programme of Action regarding adolescent sexual and reproductive health. The ultimate goal of such an assessment is to encourage planners, policy-makers and national leaders to recognize the importance of the issue and to formulate supportive ARH policies and programs to improve the provision of reproductive health information and services to African adolescents and young adults.

To achieve the primary goal of the study, the following specific research objectives have been set:

Objective 1: determine whether adolescents and young adults have been recognized as a specific target group for national health policies in Burkina Faso, Cameroon, and Togo and how this target has been defined;

Rational: Political recognition of adolescents as a target group is a first necessary step in the process of policy development. The way adolescents are defined in policies and programs is also important not only because it reveals the perceptions that policy-makers have of the issue but also because adolescents from various age groups have different reproductive health needs that should be addressed differently.

Objective 2: Assess the status of public policies, national guidelines, and governmental program initiatives regarding the provision of RH information, education and services to adolescents and young adults;

Rational: Public commitment and the existence of clear national guidelines are often key to the success of adolescent reproductive health programs (Birdthistle and Vince-Whitman 1997). As mentioned above, an assessment of the current status of the public policies and an identification of the gaps and deficiencies in both the formulation and implementation of adolescent reproductive health policies is actually the beginning of the policy making process.

Objective 3: Document the experience of non-governmental initiatives in designing reproductive health programs geared towards providing reproductive health information, and services to adolescents;

Rational : Non-governmental organizations (NGOs) have been extremely active in setting up and implementing the Cairo agenda and a review of adolescent reproductive health policies and programs would be incomplete without a review of the private effort in the domain. In the past, the pioneering efforts of many NGOs have carried important policy implications either by implementing successful projects that were later used as models by

governments or through advocacy initiatives that have led to policy formulation and change.

Objective 4: Assess the level of collaboration and synchronization in the efforts (among NGOs, and between NGOs and government);

Rational: From a public policy point of view, it is very important to assess the level of collaboration and coordination of private and public efforts, while though often proving difficult have nevertheless been the basis of successful policy and program implementation (Senderowitz 1997a; 1997b).

Objective 5: Evaluate the level of youth involvement in the design of ARH policy and programs.

Rational: Several studies have the stressed the crucial role of youth involvement when developing successful programs geared toward adolescents and youth (UNFPA 1997; Senderowitz 1997a; 1997b).

Objective 6: Compare and contrast the experience of the three case study countries in designing policies and programs geared towards adolescents.

Rational: The comparative approach allows policy-makers and program managers to benefit from other countries' experiences and provide insights with regard to what type of interventions and policies are most likely to be successful in what type of cultural and socioeconomic settings.

III. STUDY DESIGN

1. STUDY SETTING

The research contrasts the policy and programmatic experiences of three countries in West Africa: Burkina Faso, Cameroon, and Togo. The choice of the countries has been motivated by several factors. First, like in most African countries, in the three countries under study adolescents are facing very important reproductive health problems that need urgently to be addressed. High prevalence of maternal mortality among teenage mothers, unmet needs, increasing rates of abortion and STD infection, are examples of increasing reproductive health needs faced by Cameroonian, Burkinabé and Togolese adolescents (see country reports).

Second, as a group, these countries are interesting because they have, like other Francophone countries in Africa, traditionally taken a less pro-active stance in population and reproductive health policy intervention and programs, and had a less developed

population research and policy infrastructure. One expects therefore that they would face greater difficulties to implement the Cairo agenda.

Third, the three countries are representative of the socioeconomic and geographical diversity that can be found in West Africa (Sahelian, coastal and central regions). Finally, a major criterion of choice was the presence in three countries of quality research institutions (l'Unité d'Enseignement et de Recherche Démographique (UERD) in Burkina Faso, l'Institut de Formation et de Recherche Démographique (IFORD) in Cameroon and l'Unité de Recherche Démographique (URD) in Togo) and talented local researchers with whom strong collaborative links had already been established.

2. DEFINITIONS

Adolescent sexual and reproductive health issues are defined here in a comprehensive manner as issues concerning the consequences of unprotected sexual relations. These include unwanted or too-early pregnancy and childbirth, unsafe abortion, STDs and HIV/AIDS as well as sexual maturation, gender equity in sexual relationships, sexual abuse and sexual exploitation affecting youth (United Nations 1994).

One of the objectives of the study is to document how adolescents and young adolescents are defined by policy makers, and what sub-group of adolescents are typically targeted by programs. In the research we focus on policies and programs affecting "adolescents" defined as persons aged 10 to 19 years-old as well as "young adults" defined as the 20 to 24 age group. The term "youth" is used in the present report to refer to both adolescents and young adults, the larger group of "10-24 years-old".

3. CONCEPTUAL FRAMEWORK

The conceptual framework used to assess policies and public and private programs on adolescent reproductive health in the three countries under investigation and achieve the above objectives is presented in Figure 1.1. In this evaluation, the accent is put on policy and program design since a complete evaluation of the actual implementation of the policies and programs would be beyond the scope of the study. Three stages of program and policy design are examined the framework: the formulation, the implementation plan, and the monitoring and evaluation plan. The level of coordination and collaboration of private and public efforts, as well as the level of youth involvement in the program and policy design are also considered.

3.1. The formulation

- *Program/Policy initiation:* Three aspects of policy/program initiation are considered: 1. The date of creation and the development stage of the program/policy (pilot, execution, or maturity); 2. Whether the program/policy is new or is a reorientation of a pre-existing program/policy; and 3. Whether is it a national or international initiative.
- *Target groups definition:* Four dimensions are considered at this stage: 1. Whether the program focus exclusively on adolescents and young adults; 2. Whether the target group has been clearly defined; 3. The characteristics of the group targeted; and 4. Whether sub-groups of adolescents have been identified and the main criteria chosen by program managers and policy makers to define these sub-groups. The geographical scope of the targeted reached by each program and policy is also considered at this point.

- *Definition of reproductive health issues to be addressed:* The scope of reproductive issues that programs and policies intend to address are examined both in light of the ICPD Program of Action and in relation to the specific reproductive health needs of adolescents in the country (as shown in the existing research body). Attention is also paid to how reproductive health problems are defined: based on the analysis of primary or secondary data, on informal feedback from the field, using international standard, etc.

- *Program/policy objectives*: The specific objectives and goals as stated in the program and policy documents have to be evaluated. Two categories of objectives are distinguished here: those for which results are easy to quantify and those for which results cannot be easily quantified and call for a more qualitative type of evaluation (CIDA, 1997). Four dimensions to evaluate program objectives are also considered: whether objectives are explicit, clear, measurable, and whether deadlines have been established for reaching each specific objective.

3.2.The implementation plan

- *Scope of activities :* At this stage, the actual content of the program and policy is examined. Activities are classified in large groups (such as I.E.C., service provision, training, institutional support and research) and sub-groups of activities (such as I.E.C. through media campaigns, counseling activities, production of educational materials, information to parents etc.). This inventory allows observers to identify, in each country, the existing gaps in adolescent reproductive health activities.

- *Financial and human resources:* Resource constraints are a key element to take into account when evaluating programs in developing countries. Both financial and human resources are considered here. Resources indicators include: implementation structures (existing versus new), stability of the financial resources as perceived by program managers, sources of funding (international agencies, government) and perceived availability of the human resources for program implementation.

3.3. The monitoring and evaluation plan

- *Monitoring methods:* To optimize program/policy implementation, monitoring methods need to be clearly defined and planned. Two indicators are taken into account to evaluate the monitoring plan: 1. The monitoring methods selected 2. The existence of both concrete and pertinent performance indicators.
- *Evaluation plan and scheme:* Regarding evaluation, the following questions are asked: 1. Is there any evaluation plan? 2. Has the program or policy already been evaluated? 3. If so, was it an external or internal evaluation?

3.4. Level of coordination and cooperation

It is very important to assess the level of collaboration and coordination of private and public efforts. In fact, such coordination has been proven to be difficult but necessary for successful policy and program design (Senderowitz 1997a; 1997b). Cooperation and coordination between public and private initiatives are also believed to be key for flexible programming (Hughes and McCauley 1995). Thus, the number of partners involved in each program and their roles as well as the level of coordination among programs are indicators considered.

3.5. Level of youth involvement

Several studies have stressed the crucial role of youth involvement when developing and evaluating programs and policies (Senderowitz 1995; Hughes and McCauley 1995). Thus, the level and nature of youth involvement at each stage of the program design process (formulation, implementation plan, evaluation and monitoring plan) need to be assessed.

IV. DATA AND METHOD

1. DATA SOURCES

The data used in this study come from three sources: secondary data on adolescent reproductive health problems, interviews conducted among government officials and program managers, and policy and program documents.

1.1. Literature review on adolescent reproductive health needs

Key indicators reflecting the reproductive health needs of both male and female adolescents in each country have been gathered. This includes indicators such as the prevalence of early and unwanted pregnancy and childbearing, maternal mortality, STDs infection including AIDS, abortion and abortion related deaths, sexual abuse, prevalence of genital mutilation among female adolescents when available. Data on level of knowledge, use and access to contraceptive and reproductive health services and information among adolescents and young adults were also gathered. Such information was gathered using existing demographic, family planning and health surveys such as Demographic and Health Survey, hospital-based studies, qualitative studies and existing literature reviews.

1.2. Interviews with government officials and programs managers

Second, government officials and program managers were contacted and interviewed. The first step was to identify keys actors and stakeholders from both the private and public sector who are involved in the domain of adolescent reproductive health in each country. These actors include individuals who could assist in informing us about the existence of policy or on-going programs, NGOs, youth associations, and local branches of international institutions that had on-going projects focusing on adolescent reproductive health, ministries or governmental divisions involved in the design and implementation of programs and/or policies affecting adolescent reproductive health (e.g. Health ministries, or Education ministries) as well as national youth groups.

Preliminary selection of organizations and youth groups was made based on official registration lists of NGOs. For instance, the listing from the “Secrétariat Permanent des Organisations Non governmentales” was used in Burkina Faso and the “Annuaire des organisations non gouvernementales du Cameroun” edited by the UNDP was a useful starting inventory of existing NGOs used in Cameroon. Informal contacts with informants or with key persons working within the identified organizations were also used to elaborate the inventory.

An exhaustive assessment of all private initiatives targeted at adolescents was beyond the scope of the research, hence the objective was to select the 5 to 10 major non-governmental initiatives on adolescent reproductive health in each country. The major criteria used to select the organizations and youth associations were: 1. That the organizations or youth associations executing the program have at least one to two years of existence; 2. That they have a "reputation" in the field and are well-known in the country; and 3. That they have developed and implemented programs or program sections which clearly focus on ARH.

Once the ministries, international organizations, NGOs and youth groups had been selected, the next step was to send government officials, project managers, and representatives of youth groups a letter briefly presenting the project and asking for the institution participation, along with a canvass of the information needed (see Progress report No.1 for examples of letters and canvass). These individuals were then interviewed. The original standard questionnaires used for governmental and non governmental institutions are shown in Appendix 1. Following the analytical framework presented in Figure 1.1., the questionnaires include five sections: the formulation, the implementation plan, the monitoring and evaluation plan, the level of youth involvement, and the level of coordination and coordination.

1.3. Policy and program documents

Efforts were made to collect documents on programs and policies prior to or during the interviews. For public policies, these documents included constitutional clauses, executive and ministerial decrees, legislation, orders, policy statements, administrative regulations and rules, judicial decision, government program statement. For private programs initiatives, the documentation included description of the project, internal and/or external evaluation reports, strategic plans or any documentation relative to the program.

2. DATA LIMITATIONS

Two limitations to the data need to be underlined. First, some of the government policy and program documents included in the analysis have not yet been officially adopted. We decided to include them in our review not only because some of them are close to be adopted (e.g. National Youth Health Program in Burkina Faso) but also because we believe that they reflected the official position on the issue at the time. One should keep in mind, however, that they may be modified and revised before their final adoption. The results of the present study might actually help in the revision. Second, despite efforts to gather program documents, it should be noted that several non-governmental organizations, or youth associations did not provide us with any documents and we had to rely exclusively on the data gathered during interviews with program managers.

3. DATA ANALYSIS

The literature review on adolescent reproductive health problems in each country was used to establish a "facts and figures" section that is included in each country report. The purpose of this was to place the study in the context of adolescent reproductive health problems in each country as well as to draw the attention of policy makers and program managers, during the dissemination stage, to the dimensions of the reproductive health problems faced by adolescents and young adults in their country.

Both qualitative and quantitative approaches were used to analyze the interview transcripts and the program and policy documents. The qualitative analysis consisted of a content analysis of the policy and programs texts. Attention was given to the wording in the description of target groups, formulation of objectives, etc. Based on the analytical framework presented in Figure 1.1., indicators and variables were created. The quantitative analysis consisted of coding the questionnaires and entering the data in a data base to facilitate the comparative analysis of the three countries.

V. RESULTS

The results section is divided in two parts. First, the governmental initiatives in promoting adolescent reproductive health in Burkina Faso, Cameroon and Togo are presented. The non-governmental programs in ARH in the three countries are then discussed. In each section the five components of policy/program design presented in the conceptual framework are considered: program/policy formulation, implementation plan, evaluation and monitoring plans, youth involvement, level of coordination and collaboration.

1. GOVERNMENTAL INITIATIVES

The presentation of the governmental initiatives in ARH in Burkina Faso, Cameroon and Togo is divided in two sections. First, the importance attributed to the issue of adolescent reproductive health in national population, health, and education policies and programs is examined. The government initiatives to combat Female Genital Mutilation (FGM) are also presented. In the second section the national policies and programs in adolescent reproductive health per se are analyzed in more details.

1.1. ARH in national population, health and education policies

1.1.1. ARH in early national population policies

In Burkina Faso, Cameroon and Togo, the first National Population Policies (NPP) were elaborated shortly before the Cairo conference (in 1991, 1993 and 1991 respectively). In the three countries, the NPP is an important policy document, often considered as a reference framework for population and development related activities. Its analysis also provides an idea of the Government's position vis-à-vis youth and youth's reproductive health before the ICPD.

In Cameroon, the *Declaration de Politique Nationale de Population* (DPNP) was adopted in July 1992. Although the term "reproductive health" is absent from the DPNP, issues of early childbearing, maternal mortality, unwanted pregnancies, abortions and STDs are mentioned in the document. "Youth", a generic term to describe the population under age 20, is recognized as a specific target for employment, health and education policies. In the area of health, mothers and children, rather than adolescents per se, are the main targets of the DPNP. Thus, when they are mentioned, adolescent reproductive health problems are mainly those of adolescent mothers.

The initiatives recommended by the DPNP to combat early childbearing and undesired pregnancies among female adolescents consisted mainly of "increasing level of formal education among girls" (République du Cameroun 1993:15), and "promoting Family Life Education (FLE) and sex education among youth taking into account their level of maturity" (République du Cameroun 1993:35).

In Burkina Faso and Togo, the Government's positions on ARH as stated in the National Population Policy are very similar to the ones of the Cameroonian government: the concept of ARH is absent and, when identified, ARH issues are mainly those of adolescent mothers. Provision of ARH services amounts to promoting FLE referred as "population education" in Burkina and "Education in Population and Environment for Sustainable Development (EPD)" in Togo. Among the 24 specific objectives of the 1991 Burkinabé Politique de Population, for instance, the only two concerning youth were:

- "to make population information to promote responsible parenthood available to the largest number of persons, and especially adolescents, before year 2005 "
- "to continue the introduction of population education in the formal education system, and extend it to the non-formal system and the adult literacy programs" (CNP 1991: 30).

The lack of political concern for ARH is also visible in the strategic population program, "*Programme d'action en matière de population*" (PAP) which was elaborated in 1992 to implement the NPP. In this program, the component "Population and Youth" essentially

targets: rural exodus, protection against juvenile delinquency, and creation or reinforcement of educational structures. In addition, only 0,7 percent of the total budget was devoted to this component.

1.1.2. ARH in revised national population policies

The orientations of the Cameroonian government in the area of population and development, as expressed in the NPP, have not been officially modified after the Cairo conference (although some information gathered on the field suggest that the policy may be under review). The Burkinabé and Togolese governments, on the other hand, have revised their population policies in 1996 and 1998 respectively.

The intention of the Burkinabé government to implement the recommendations of the Cairo conference was first reflected in the adoption of a *Letter of Intent on Substainable Human Development* in 1995. In this letter, five components of well-being and quality of life are identified: economic security, food security, health security, environmental security, and individual and political security. In the area of health security, two general orientations mark the emergence of the concepts of reproductive health and adolescent reproductive health: the implementation of the Primary Health Care (PHC) strategy and the integration of family planning (FP) and Maternal and Child Health (MCHC) services under the PHC system, and the inclusion of "youth health" in the "*paquet minimum d'activités*" (minimum activity package).

Following the adoption of a *Letter of Intent on Substainable Human Development*, the Burkinabé Government started updating the NPP in 1996 to reflect its new orientations and the recommendations of the Cairo conference. In this new NPP, which should be adopted soon, the concept of RH is also brought forward and "adolescents and youth" are recognized as a "vulnerable group" to be targeted by national policies.

The new NPP includes specific objectives and strategic orientations that concern ARH directly. The objective 1.1. is to "Promote greater use of RH services particularly among women, adolescents and youth." and the strategic orientations proposed to achieve this objective include: 1. Promotion of RH integrated services or youth oriented RH services; 2. Community involvement in the implementation of youth structures; and 3.Use of peer techniques to sensitize and inform youth.

The "promotion of Information, Education and Communication (IEC) programs in FP among target groups" and the "promotion of FLE and sex education in the formal and informal education systems" are also mentioned as important strategic orientations to "increase the contraceptive prevalence from 4.76% in 1998 to 18.75% in year 2015" (specific objective 1.5).

To implement this new NPP the "Conseil National Population" of the Burkinabé Government has elaborated a second strategic action program, the "*Programme d'action en matière de population*" (PAP II) for 2001-2005. In the introduction of the document, which has not yet been officially adopted, the impact of the resolutions taken during the Cairo conference on the new orientation taken by the Government is clearly visible. The general objectives of the PAP II are the specific objectives presented in the new NPP. To achieve these objectives, the PAP II has elaborated 5 "sub- programs" for which specific objectives and expected outcomes are presented. One of the sub-programs is entitled "Health and Reproductive Health". In this sub-program, one of the specific objectives is "to increase the number of structures offering RH services to youth and adolescents by year 2005 in both rural and urban areas with the participation of community and youth". The expected outcomes are:

1. 10% of existing basic health structures and referring structures offer RH2 services to adolescents and youth
2. The 8 existing youth centers are reinforced with regard to the provision of ARH services
3. 10 new centers for the provision of ARH are opened and functional in both rural and urban areas, with the participation of youth, communities and departmental structures in charge of youth.

In Togo a new National Population Policy was adopted in October 1998. As opposed to the new NPP formulated in Burkina Faso, the orientations presented in the 1998 Togolese NPP do not strongly reflect the priorities of the ICPD Agenda in the area of ARH. The concepts of reproductive health and adolescent reproductive health are surprisingly absent from this document.

If "children and youth", as defined by "the population under age 20", are recognized as a "vulnerable group" facing important problems, the issues identified consist mainly of: "delinquency, drug abuse and other form of exploitation, and lack of parental control" (République Togolaise, 1998:29). One of the 12 objectives set by the 1998 NPP, is to "improve the life conditions of children and youth". The strategies to reach this objective include 1. Protect youth against exploitation through the elaboration and implementation of adequate legal texts; 2. Protect youth against cigarette smoking, and drug use through IEC and 3. Promote and generalize FLE in schools and out of schools. Nothing is specifically said about ARH in this objective.

The only ARH problem mentioned in the 1998 NPP is early childbearing (among girls less than 20). The first objective of the NPP is "to control fertility through the promotion of FP which prevalence rate should go from 9.1% in 1997 to 50% in year 2020". The strategies include 1. To modify the 1920 French law which prevents the publicity and

commercialization of contraceptives,[1] 2. To increase the minimum age at first marriage to 20 years old for girls and 21 years old for boys, 3. To prevent early childbearing through the generalization of population education and FLE.

Thus, like the early NPP, direct reference to the concept of ARH is absent from the new Togolese NPP, early childbearing is the only ARH identified and the provisions of ARH services amounts to promoting FLE among youth.

1.1.3. ARH in national health policies

Overall the IPCD has marked a turning point in the orientation of health policies and programs in the three countries. The level of development of the section dedicated to youth and ARH in national health policies varies from one country to the next, however.

In Burkina Faso, the development in 1998 of a new *Strategic Plan for Reproductive Health (1998-2002)* reflects the new orientation taken by the Government as expressed earlier in the *Letter of Intent on Substainable Human Development*, the revised NPP and PAP. Like the revised NPP and PAP, however, the Strategic Plan for Reproductive Health has still not been officially adopted.

In this document, "Youth sexual and reproductive health" is identified as one of the four programmatic domains of the RH policy. "Youth and adolescent" have not been defined clearly, however, and no specific sub-groups of adolescents and youth have been specified. "Health of youth and adolescents is now a major concern for the Government" it says (Burkina Faso 1998: 13) and early childbearing, unwanted pregnancies, illegal abortions, exposure to STDs including AIDS, lack of information about sexuality and inadequate RH services are ARH problems underlined in the document.

In the area of ARH, the general objectives are "to help youth to better understand their sexuality to promote responsible behavior and provide them with services they need" and "to reduce the number of unwanted pregnancies. The following specific objectives have also been set:

- To put specific counseling services at the disposal of youth
- To reduce by 25% the present level of early and unwanted pregnancies among female adolescents

To achieve these objectives, youth-oriented activities planned in the context of the Strategic Plan for Reproductive Health and in each strategic domains include:

[1] Although the 1920 French law, which prevents the publicity and commercialization of contraceptives, is not enforced in Togo it still has not been abolished.

Strategies	Activities
Capacity reinforcement and decentralization of services	- Elaboration of protocols to promote access to contraceptive methods among youth - Formation of teachers and professors to communication and counseling techniques - Creation of specific health and counseling structures for youth - Expansion of the contraceptive distribution system - Regular provision of basic product and equipment
IEC and advocacy	- Promote dialogue between parents and adolescents on sexuality and responsible parenthood - Organization of holiday clubs on FP, sexuality and unwanted pregnancies for pupils and teachers
Promotion of women and young women status	- Promotion of FLE
Reinforcement of inter-sector collaboration and partnership	- Creation of a network of actors in RH to harmonize youth-oriented actions
Promotion of research activities	- Research on youth and male participation to FP

Plan Statégique de la Santé de la Reproduction du Burkina Faso 1998-2008, Ministère de la Santé, Direction Générale de la Santé Publique, Direction de la Santé de La Famille September 1998

As seen in the above table, the range of strategic approaches is large. Important strategic areas such as the collaboration among private and public actors working in RH and among various sectors of public services; the promotion of research, and the promotion of women are taken into account. The description of the activities to be conducted, however, lacks precision. For instance, how will the "the dialogue between parents and adolescents" be promoted? How many centers will be created?". As opposed to the PAP II, presented in the above section no expected outcomes have been set up.

In Togo, the concept of RH is first mentioned in the National Health Policy adopted in 1996. This recommends the elaboration and the implementation of "a reproductive health program that integrates MCH, contraception, STDs/AIDS, sterility, adolescents and youth health, traditional practices harmful to women and children" (République Togolaise 1996: 13). Thus, the impact of the 1994 ICPD on the orientation of national health policies becomes visible in Togo in a document entitled "*Reproductive Health Policy and Standards in Togo*" elaborated in June 1997 by the Family Health Division (DSF) of the Togolese Ministry of Health. In the preamble to the document, the influence of the IPCD Agenda on these new orientations is clearly mentioned and the Government

states that with this document "Togo adopts the international definition of reproductive health" (République Togolaise 1997a :5). Four RH components are distinguished: womens' health; child health; adolescent and youth health and male health. Youth are defined as persons aged 10 to 24 years old, and the general objective of the youth health component is "to promote a state of complete physical, mental and social well-being among adolescents and youth aged 10 to 24 years-old, in school, universities, and out of school" (République Togolaise 1997a :5). As seen in this objective, two sub-groups of youth: those in school and those out of school are distinguished.

To achieve this general goal, eight specific objectives have been set, including:

1. Prevent and take care of pathologies, sexual dysfunction and troubles among adolescents and youth
2. Prevent early pregnancies, induced abortions, and STDs/AIDS by the provision of adequate contraceptive services.
3. Promote sanitary activity in EPD
4. Promote pre-natal visits

When describing the activities planned in the area of ARH a distinction is made between adolescents in school and adolescents out of school. Activities directed toward youth enrolled in school and at the university include: curative care; systematic medical visits; IEC (prevention of risky behavior, EPD¸ gender approach); conferences/debates; provision of RH services; "youth for youth" activities; diffusion of legal texts; vaccination; referral; prenuptial visits. Activities planned for youth out-of school include: IEC in neighborhoods and villages; "youth for youth" activities; creation of youth centers, prenuptial visits. Specific activities to be conducted at each level of the health structure and indicators of performance for each of the activities are also presented.

In Cameroon, the impact of the ICPD on the elaboration of new health policy is less obvious. The development and adoption in 1995 of the *Maternal and Child Health Care and Family Planning Services (MCH/FP) Policy and Standards* by the Ministry of Public Health exemplifies, however, a new orientation of the Cameroonian Government in the area of health. The MCH/FP policy marks the integration of FP services with maternal and child health services and the emergence of the concept of reproductive health (although the term is never mentioned in the document).

Like in Burkina Faso and Togo, the MCH/FP policy recognizes the adolescents as one of its target groups. The definition of youth is, however, more narrow and they are defined as "persons aged 11 to 19 years old", a slightly modified version of the definition from the World Health Organization (WHO). A opposed to Togo, no distinctions are made among sub-groups of adolescents and youth (according to sex, age or school status). The MCH/FP policy includes six components: pre-conception care, prenatal care, intrapartum care, postpartum care, care to newborn and children, and adolescent care.

The objectives of the adolescent care component, as presented in the policy document, are formulated in very general and vague terms. Adolescent care "aims at of the physical, mental, and social health of this group by a multidisciplinary and multilevel approach (République du Cameroun 1995:4)".

Activities targeted at youth are defined as follows: "FLE for a responsible parenthood, sex education, prevention of early pregnancies, prevention of early marriages, prevention of induced abortion, and prevention of STDs/AIDS." (République du Cameroun 1995:4). The document remains unclear on the actions to be implemented to prevent early pregnancies, abortions and STDs, however. In the section on MCH/PF describing the activities to be implemented at the health centers, district hospitals, and central hospitals levels, the activities directed towards youth include "supervision of pregnancies among adolescents, sex education and FLE, screening of adolescents at risk, referral of difficult cases, risky pregnancies."

As in the DPNP, the MCH/PF activities described focus on education (FLE and sex education) rather than on access to RH services per se (contraception, STD/AIDS screening etc.). Additionally, the analysis of the content of FLE targeted at youth reveals that the information on FP is excluded from the FLE targeted at youth while it is included in the FLE curriculum for other targets (e.g.: parents). FLE education for youth includes "individual essential needs, family relationship, sex education, prenuptial exams, STD/AIDS and STD/AID prevention".

Thus, there seems to be in the MCH/FP policy the same reluctance as there is in the PNP, to address the issue of access to FP information and use of FP services by adolescents. Although the PF policy declares that "every person of reproductive age is entitled to information on FP" (République du Cameroun 1995:6) and has the right to contraception" (p.7), it is clear from the DPNP and the MCH/FP policy that the government approach to ARH focuses on access to RH information rather than access to RH services. Additionally, the policy does not recognize the need to create special health structures or centers, like in Burkina Faso and Togo, for meeting the reproductive health needs of youth or adapt the existing regular MCH/FP system to satisfy those needs.

The recognition of adolescents and young adults as a specific target of national health policies and programs, in the three countries, is also visible in national programs to combat MST and AIDS.

1.1.4. ARH in national program to combat HIV/AIDS

While programs to fight against AIDS have been implemented in the three countries before the ICPD, the influence of the Cairo conference and the place conferred to youth is manifest in the more recent or re-oriented programs.

In Burkina Faso, for instance, the "*Plan National Multisectoriel de Lutte contre les MST/SIDA*" elaborated in 1994 in the context of the Population and Fight against AIDS Project (PPLS), includes a series of IEC activities specifically targeted at youth: creation of an information, counseling and STDs screening center for youth in Ouagadougou; support of an "IEC-Youth" campaign in the regions; and creation of school magazines on STDs/AIDS.

In Cameroon, the new " *Plan cadre de lutte contre le SIDA au Cameroun* (National plan to combat AIDS in Cameroon) elaborated in 1999 by Ministry of Health, also recognizes youth as a specific target. One of the objectives of the national plan is to "sensitize the population aged 15-24 with gender-specific methods" (République du Cameroun 1999:4). Like in Burkina Faso, the accent is put on IEC activities. The training of peer educators in STDS/HIV/AIDS prevention seems to be the principal method chosen to reach youth: training of young adults responsible for health clubs in schools, training of trainers in driving schools, training of teachers and students in "teaching schools" (*Ecoles Normales*). Screening of STDs and clinical care of HIV infected patients are also planned but they target the "population at large" and do not target youth specifically.

Finally, in Togo, the *National Program to Fight Against AIDS* (PNLS) has recognized both youth in school and youth out of school as specific target groups. The age group targeted is broad and includes youth aged 8-30 years old, probably to include all age groups represented in school. The description of youth-oriented activities collected during interviews suggests that, like in Burkina Faso and Cameroon, they essentially consist of IEC activities: peer education and information campaigns among out of school adolescents and young adults and FLE and IEC among youth enrolled in school. In schools, 600 biology teachers were trained in IEC for STD/AIDS prevention at the secondary level, and 116 primary schools were targeted.

1.1.5. ARH in National Education policies and programs

As seen above, FLE (referred also as Population Education in Burkina Faso and EPD Togo) was already a priority expressed in the early national population policies in the three countries. The necessity to further develop FLE programs was stressed by the national health policies elaborated after the 1994 ICPD and FLE programs have been in effect strengthened or re-oriented after the Cairo Conference in Burkina Faso, Cameroon and Togo.

In Burkina Faso, a "strategy for the introduction of population education in the formal system" was elaborated as early as 1985 and implemented by a national program co-financed by the United Nations Population Fund (UNFPA) in 1987. The adoption of the PNP and the PAP in 1992, the Third UNFPA cooperation program (1992-1996) as well as the 1994 ICPD gave a new boost to initiatives promoting FLE among youth. While the

integration of population education was initially done at the secondary school level, the objective was to generalize it to the whole educational system. Thus, the existing program in FLE was strengthened and the target group of FLE was extended to adolescents enrolled at the primary level.

Besides the extension of the FLE program to the primary level of formal education, two programs were elaborated to target youth enrolled in the non-formal education system. The first program entitled "*Population education for rural youth*" was elaborated in 1995. The program targets rural youth enrolled in agricultural training centers (CFJA) and is implemented by the Ministry of Agriculture. Its objectives, as stated during interviews with Ministry representatives, are "to introduce population education in the training curriculum in the CFJA" and to "provide rural youth with RH information and promote responsible parenthood". Similarly, the program, "*Population education in the literacy campaigns*" was launched in 1996 to target youth and adults enrolled in literacy centers. The objectives of the program are: "to generalize population education to the non-formal system" ; "to reduce the rate of girls dropping out of school" and "to promote responsible sexual behavior among youth".

According to interviews, the RH aspects stressed in the population education in the three programs include: "adolescent sexual and reproductive health", "combat STDs" and "promote responsible parenthood".

In Cameroon, the 1988-1992 UNFPA cooperation program and the DPNP have emphasized the promotion of IEC activities and the introduction of FLE in school curricula. In 1995, the *Loi d'orientation scolaire* ("law of education orientation") makes the introduction of FLE a priority. Following this law, a document entitled *Déclaration de politique de santé en milieu scolaire* ("Declaration of health policy in school environment") was drafted by the Cameroonian Ministry of Education. This policy, still to be adopted, targets pupils and students from the kindergarten (4-6 years old), primary (6 to 11 years old) and secondary level of education (11-21 years old).

According to this policy, one of the components of the primary health services to be implemented in schools is FLE. The analysis of the document does not allow, unfortunately, to determine if FLE is the only reproductive health activity planned. Indeed, if, according to the document, some "health services", will be provided to children and adolescents in school, through either the school nurseries (*infirmerie d'école*), the health centers (*centres médico-scolaire*), or health clubs, the description of these services is not precise enough to determine whether reproductive health services are also programmed as part of activities.

In Togo, like in Burkina Faso and Cameroon, under the UNFPA country program, the FLE program was introduced early (1985) in the education system. In 1995, the initial program entitled *EmP/EVF program* (Population Education and FLE) was revised and extended. The content of the program was updated "in accordance to the

recommendations of recent international conferences" (République Togolaise 1996: 3), to integrate new issues such as reproductive health, sustainable development, and gender equality. The objective of the new program was to continue the introduction of EPD at the secondary level education and extend it to educational institutions such as ENS (Ecole Normale Supérieure), INSE (National Institute of Educational Sciences) and DIFOP (Direction de la Formation Permanente, de l'Action et de la Recherche). The activities include the training of teachers and professors (1064 at the secondary level, 20 in INSE, 21 in ENS, 34 in DIPOD); training of inspectors, elaboration of new curricula, and IEC activities among parents of students and community leaders around the schools (e.g. conference, film, radio shows etc.).

The component "Reproductive Health" of the EDP covers issues such as: prevention of STDs/AIDS; induced abortions, early pregnancies, responsible parenthood and knowledge of the functioning of human reproductive system. As mentioned above, gender issue was also included in the new curriculum.

1.1.6. National policies and programs to eliminate FGM

Female circumcision or Female Genital Mutilation (FGM) is a harmful traditional practice that may threaten adolescent health. This practice of removing some or most of the external female genitalia has been a traditional rite for initiating girls into adulthood. It is performed in the three countries (see country reports). Since the procedure is often carried out with unsterilized instruments and little post-procedural treatments, many disastrous health complications can be associated with it (infection, hemorrhage, recurrent urinary tract infection, painful menses, sexual complications and problems during childbirth). In Burkina Faso, Togo and Cameroon, recent governmental initiatives to combat FGM are worth noting.

In Burkina Faso, where the prevalence of female excision is very high (about 70 % of girls are estimated to have experienced it), the scale of this phenomenon has lead to the establishment of a National Committee to Combat Female Circumcision (CNLE) and the adoption of a national plan in 1992 to combat FGM. Through advocacy and IEC activities, the CNLE along with NGOs articulated the harmful consequences of FGM and were able to convince policy makers and the Assembly of the need to legislate against it. The political will to fight this practice is also visible in the new PAP (section 1.1.1) which set the objective to "eliminate before year 2015 the practice of female genital mutilation". More specifically, the PAP planned to "reduce from 66% to 20% among girls aged 0 to 20 the prevalence of FGM" by, among other things, enforcing the legal texts, conducting operational research, conducting advocacy campaigns among the general public and community leaders, and training FGM excisers for new employment opportunities.

In Cameroon, where the prevalence of FGM is lower than in Burkina Faso but female excision is still practiced in three of the ten provinces, a *National Action Program for the Elimination of FGM* (PANEM) has been elaborated the Ministry of Women's Condition in December 1998. Like in Burkina Faso, the action plan targets mostly the public at large, excisers (traditional midwives), opinion leaders, social workers, women associations. Youth and adolescents are also sensitized through IEC activities (plays, concerts etc.). While the PANEM is articulated and well-developed, it has not been adopted yet, and no legal action has been taken to make FGM illegal in Cameroon.

Finally, in Togo following the publication and diffusion of the results of a survey conducted by URD in 1996 on FGM, a law against FGM (law N^{O} 98-016) was approved on November 17 1998. With this law, the practice of FGM becomes illegal in Togo and any person performing female excision may be sentenced from two to five years in prison and will have to pay an amount from 100.000 to 1.000.000 CFA Francs "or one of these two sentences." (law N^{O} 98-016). While the law against FGM is an important step in the battle against female excision, no preventive program, like the ones formulated in Burkina Faso or Cameroon, has been elaborated in Togo.

1.1.7. Other initiatives: the multimedia campaign in ARH in Burkina Faso

The increasing importance of the issue of ARH on Governments' agenda is also exemplified by the "*Multi-media campaign in Youth and Reproductive Health*" launched in December 1997 by the Burkinabé Ministry of Health. The main objectives of the campaign were to: "use all possible media channels to inform the public at large on important aspects of ARH"; "involve the political, administrative, religious, and traditional authorities in the campaign". As seen in the objectives, the target audience for the campaign is not restricted to adolescents and young adults even if some activities (such as radio games or distribution of T-shirts) were targeted at them. Importantly, while the campaign is entitled "youth and reproductive health" the prevention of STDs/AIDS is the main aspect of reproductive health brought forward in this program financed by the PPLS (see section 1.1.4).

1.2 Formulation of specific Programs and Policies in ARH

The final outcome of the emergence of the concept of adolescent reproductive health in the national policies is the elaboration in Burkina Faso, Cameroon and Togo of specific policies and programs in ARH. The three experiences are contrasted based on the conceptual framework presented in Figure 1.1., and the following aspects of the program/policy design are examined: the initiation of these policies and program, the definition of target groups and reproductive health issues addressed, the formulation of objectives, the implementation plan, the monitoring and evaluation plan, the level of

coordination and collaboration with other governmental and non-governmental actors and the involvement of youth.

1.2.1. Policy/program initiation

As seen in the above sections, the Cairo Conference has impacted the formulation or re-orientation of national population, health, education policy and program in the three countries and adolescents and youth are now recognized as specific targets of national policies and programs. The formulation of specific youth health policies is the logical step following this recognition.

The level of advancement of the formulation of these programs and policies varies from one country to the next, however. While *the National Adolescent and Youth Health Program* (PNSJA) in Togo was adopted in November 1997, in Burkina Faso and Cameroon no program or policy in adolescent health or reproductive health has been officially adopted yet. In the two countries, however, a National Youth Policy/Program is being prepared. In Cameroon, a project entitled "*Project of National Adolescent Health Policy of Adolescents in Cameroon*" was drafted in 1996 and revised in 1998 by the Ministry of Public Health. In Burkina Faso, a provisional policy document entitled "*National Youth Health Program (1998-2002)*" was also prepared by Kangoye and Kaboré upon request of the Ministry of Health. It may be adopted soon.

In Burkina Faso and Togo the commitment of the Government to address the RH needs of adolescents was also shown in the creation of a National Youth Unit within the Ministry of Health, which has preceded the elaboration of the youth health programs there. In Burkina Faso, a Youth Services Department was created in 1996 within the Department of Family Health to "better address the needs of young people and involve youth associations in the implementation of population programs." In Togo, the National Service for Youth Health (*Service National sur la Santé des Jeunes*) was created in May 1996. The mission of this National Service, as stated in the program document was to: "document the health problems of youth and adolescents; implement structures to provided adequate health services to youth and adolescents, and establish an efficient framework of collaboration and coordination among actors in the area of youth health" (République Togolaise 1997b: 1).

1.2.2. Target Group definition

We examined how the target groups of the (future) Youth program were defined in the policy documents. In the three countries, the group targeted by the Youth program is the age group between 10 and 24 years of age. In Cameroon, while the MCH/FP policy had defined youth as persons aged 11 to 19 years old (see section 1.1.2), the draft document of the youth program recognizes the need to extend the target group to the 10-24 for "strategic reasons".

Adolescents do not constitute an homogenous group, and youth from various sub-groups (age or gender groups for instance) have different reproductive health needs that should be addressed differently. While the (future) national youth health programs/policy in the three countries have targeted adolescents at large on the basis of age, we looked at whether or not sub-groups of adolescents have been identified as specific targets.

Consistent with the 1996 "Reproductive Health Policy and Standards in Togo" (section 1.1.3), the PNSJA in Togo distinguishes two specific sub-groups of adolescents: those in school and those out of school. The PNSJA recognizes that both sub-groups of adolescents do not face the same type of RH problems. In addition, among the adolescents and young adults out of school, four criteria for differentiating the groups were identified: occupation, socio-cultural environment (rural versus urban) level of education and age (Ministère de la santé 1997) . The document stresses the need to take into account these factors of heterogeneity among adolescents when designing strategies to improve their health status.

Similarly, the draft of the future National Health Program for Youth in Cameroon has identified the following subgroups of adolescents: youth and adolescents in school, youth and adolescents out of school, and youth in "difficult circumstances" ("moral danger, handicapped "etc.). In Burkina Faso, on the other hand, no clear sub-groups of adolescents to be targeted were identified.

Importantly, while gender equality is an overriding and basic principle behind the Cairo Agenda and behind the concept of RH, no gender distinction was made in the definition of target groups.

Finally, in the three countries, while adolescents and youth aged 10-24 were the primary target groups of the national youth health programs, other groups such as parents, community leaders, teachers, health providers were also the beneficiaries or "secondary targets" of specific training, IEC or advocacy activities.

1.2.3. Definition of reproductive health issues to address

In the three countries, the national youth health programs implemented, or to be implemented, do not focus on reproductive health specifically. All three programs are concerned with adolescent health in general and issues such as alcohol, cigarette and drug consumption, road accidents, suicide, nutritional deficiencies are also considered. However, reproductive health is at the heart of the three programs which recognize issues such as early pregnancy, undesired pregnancy, induced abortion, and STDs/HIV infection as pressing issues faced by Togolese, Burkinabé and Cameroonian adolescents. In Burkina Faso, FGM is also included in the list of the ARH issues identified. In the three

countries, however, issues of gender inequity, sexual behavior and sexual abuse in relationship were not mentioned.

Importantly, in the three countries, the documents have underlined the lack of adequate health services to satisfy youth RH needs. The difficult access of adolescents and young adults to the traditional health services due to lack of financial resources, privacy and/or unsympathetic reception by health practitioners were also mentioned as a important issues to address.

To define the RH issues to be addressed by national program and policies and the RH needs of adolescents and young adults, the policy documents have drawn on existing data from the DHS, local surveys, census, and the like. The influence of the Cairo Conference and the ICPD Agenda in defining issues to be addressed is also clearly acknowledged in the policy documents, especially in Burkina Faso and Togo.

1.2.4. Evaluation of objectives formulation

In evaluating the three (future) National Youth Programs/Policies, we examined whether or not precise, measurable objectives had been set and whether these objectives included deadlines. The National Youth programs elaborated in Burkina Faso and Togo have set both general and specific objectives and for each specific objective some indicators of performance ("monitoring indicators" in Togo and "results indicators in Burkina Faso") were formulated. Clear deadlines were also included in the Togolese and the Burkinabé programs to achieve these objectives. Some of these are no longer feasible. For example, the deadlines set by the National Youth program in Burkina Faso to conduct several activities (in 1998 and 1999), have already been passed since the project has not been adopted yet.

In Cameroon the policy document relative to the National Health Policy for Youth project is still a draft and only general objectives have been formulated. These objectives are phrased in vague terms and remain difficult to quantify. The 16 objectives that have been set, for instance, include: "train adolescents for a responsible management of their health problems at all levels" or "help adolescents and young adults to avoid unwanted pregnancies and STDs" or "encourage a healthy and responsible among adolescents".

1.2.5. Objectives and scope of activities

The scope of activities planned by the three national youth health programs to implement their objectives is very broad and, overall, the three plans are ambitious. Activities related to reproductive health include IEC and advocacy, provision of RH services by the reinforcement of existing health infrastructure, training of health personal, research activities, and political and legal actions in favor of adolescent health.

The national programs in Burkina Faso and Togo, as well as the future national policy in Cameroon, have stressed the importance of changing the attitude towards adolescent health and promote favorable behaviors. In Cameroon for instance, the policy objectives include: "create messages for the public to promote a liberal but responsible attitude vis-à-vis youth sexuality", "sensitize national community on taboos, beliefs and traditions that are harmful to youth health", and "sensitize political and religious leaders, authority figures to health problems specific to youth". Similarly, in Togo the third general objective is to "bring youth and adolescents, communities, opinion leaders, political and religious authorities to adopt favorable attitudes vis-à-vis the promotion of youth health". In Burkina Faso, the National Youth Health Program aims at "Increasing the level of knowledge about youth health among target groups in order to bring favorable behaviors vis-à-vis youth health". To do so, a wide range of IEC and advocacy activities are planned including: production of IEC materials (posters, brochures, t-shirts …), information sessions for social workers, parents, promotion of discussions and debates among parents and adolescents, radio shows, plays and IEC for the general public.

Besides IEC and advocacy, the three program/policy plans have recognized the need to increase and improve access of adolescent and young adults to health services. In Burkina Faso, the first objective of the national Youth Health program is to "increase the accessibility of health services," and the second is to "offer quality services in health structures". In Cameroon, the National Health Policy for Youth wants to "promote the access of adolescents to adequate care services" and in Togo the objective is to "make available adequate structures and resources for the provision of quality health service targeted at youth" in order to "reduce morbidity and mortality associated with early sexuality, STDs/AIDS, accidents on the road, drug usage, and other risky behaviors among adolescents and youth". To achieve these objectives, the strategy of the PNSJA in Togo is to provide adequate equipment (medicine including contraceptives) and personnel to existing health structures (training health personnel to be more "youth-sensitive") as well as to create new health units in schools and 3 health centers by prefectures. Similarly, in Burkina Faso, among other things, 10% of existing basic health and referring structures should be offering RH services to adolescents and young adults and nurseries (*infirmeries*) should be opened in schools, the equipment existing youth centers should be reinforced and training of health practitioners is also planned. In Cameroon, the description of the activities to be conducted to improve the provision of health services to youth remains vague ("screening", "health care", "counseling" activities).

The need to conduct research activities is also emphasized in the three policy documents. Objective nº8 of the Burkinabé Youth Health Program is to "promote research in various domains of adolescent health and nutrition". In Togo, a national KAP survey on youth health is planned among adolescents and young adults, parents, teachers, opinion leaders, political and religious authorities and health providers. In Cameroon, while no details are provided on the content of the research to be conducted, "operational research activities" are programmed by the National Youth Health policy.

Finally, the revision and diffusion of legal texts relative to adolescent health is mentioned in the policy documents in Burkina Faso, Cameroon and Togo. One of the objectives of the Burkinabé National Youth Health is to "create a legal environment favorable to youth health", which involves the evaluation and revision of existing legal texts on Youth Health, and the diffusion of legal provisions at various levels of the health service system. In Cameroon, the need to "revise the existing legal texts and to elaborated a legal framework adapted to adolescent and young adult's health" (p.9) is mentioned and in Togo proposals for "new legal texts in favor of youth health" is also planned.

1.2.6. Resources availability

Resource constraints is a key element to take into account when evaluating programs in developing countries (Hughes and McCauley, 1998). The present analysis reveals that lack of adequate funding has been a critical issue in the implementation of the PNSJA in Togo. According to the interview conducted with representatives of the Health Ministry, while the human resources were adequate for the implementation of the program, lack of funds has postponed the actual launching of the program and only few of the activities planned have been conducted so far.

Since the National Youth Health Program in Burkina Faso and the National Youth Health Policy in Cameroon have not been adopted yet, the representative of the health ministries were not interviewed regarding the funding sources for the implementation. In the two documents, the section devoted to financing source remains very brief. In Cameroon, "the international organizations" and the "bilateral and multilateral cooperation" are mentioned as potential financing sources. In Burkina Faso, while the necessary human and financial resources have been identified and a budget has been presented, no information is provided on the funding sources.

1.2.7. Level of coordination and collaboration

The importance of coordination and collaboration among public and private actors working in the area of youth health is stressed in all three program/policy documents, especially in Burkina Faso and Togo. In Burkina Faso, one of the specific objectives is to "create an institutional framework to implement the youth health program at all level of

the Ministry of Health (central, intermediary, and peripheral) in collaboration with other youth programs" (Kangole et Kabore 1998:63).

Similarly, in Togo, the fourth intermediary objective of the National Youth Program is to "reinforce relations among actors working in youth health (Ministries, NGOs, Associations) by implementing a formal structure for the coordination of activities, the harmonization of objectives and the standardization of management tools" (République du Togo,1997:18). Activities recommended to achieve this objective include creating a national and regional inventory of all actors working in the area of Youth Health; organizing, every year, a national workshop for governments representatives, NGOs, associations and funding agencies; and creating a committee for the elaboration of standard management tools (data collection, monitoring, evaluation etc) available for users.

In Cameroon, although the draft version of the future National Youth Health Policy does include NGOs and national and international agencies in the list of those who would be the main participants in the implementation of the policy, the recognition of the collaboration and coordination necessary among programs is less obvious and is not included as part of the policy objectives.

Importantly, while the need for coordination of public efforts across various ministries or across different sections of a same ministry is stressed in all three program/policy documents, the lack of reference to other policy or program dimensions in these documents is striking. In Burkina Faso, for instance, the objectives of the new NPP and PAPII regarding youth health are not mentioned in the National Youth program. Similarly, in Cameroon and Togo, no reference to previous or on-going initiatives in the area of adolescent reproductive health (see above sections) is made.

1.2.8. Youth involvement

Several studies have stressed the crucial role of youth involvement as an important ingredient in the development and evaluation of programs and policies (Senderowitz 1995; Hughes and McCauley 1995). In Cameroon "the involvement of youth in the existing structures" is part of "the global strategy" of the National Health Policy for Youth. The description of the mode of youth involvement in the "structures" remains vague, however: "organization of adolescent movements", promotion of youth clubs by youth", "reinforcement of dialogue structures" (MINSANTE 1998: 16). Similarly, in Burkina Faso on page 39 of the policy document one reads "in this program, youth involvement, from the elaboration until the evaluation, is a necessity". No further details are provided, however, on how youth will be involved in the formulation, implementation and evaluation of the program. Finally, in Togo, if youth involvement is not mentioned in the PNSJA document, a representative of the Ministry of Health stated in interview that

youth organizations had been invited to national workshops to discuss the content of the program.

Public commitment to recognize adolescents and young adults as a specific target for national health policies and the existence of clear national guidelines expressed in governmental policies and program are necessary conditions for the promotion of ARH in Burkina Faso, Cameroon and Togo. A review of ARH initiatives in the three countries would be incomplete, however, without a review of the private effort in the domain.

2. NON-GOVERNMENTAL PROGRAMS IN ARH

As mentioned above, the objective of the study is not to make an exhaustive assessment of all private initiatives targeted at adolescents but rather to evaluate and analyze the major private initiatives on ARH. The programs considered in each country and the organizations or associations implementing them are shown in Table 2.1.

As seen in Table 2.1., the number of programs in ARH varies from one country to the next. Fewer programs in ARH were inventoried in Togo (5 programs) than in Burkina Faso (8 programs) and Cameroon (11 programs). This variation is, in part, explained by the difference in size, Togo being the smallest country of the three (eight times smaller than Cameroon and five times smaller than Burkina Faso). The difficult political climate and the violent uprising in recent years may also have negatively affected the involvement of international NGO and the international support to local NGO in Togo, reducing the number of non-governmental programs in the country. Youth organizations seem to have been more dynamic in implementing RH programs in Burkina Faso than in Cameroon and Togo: while most non-governmental programs have been formulated by NGO or international organizations in Cameroon and Togo, three of the eight Burkinabé programs have been elaborated by youth organizations.

Table 2.1. Main non-governmental programs in ARH in Burkina Faso, Cameroon and Togo

Executing agencies (acronyms)	Organization type	Program name/title
BURKINA FASO		
ABBEF	NGO	Centres Jeunes pour Jeunes
Population Council	International organization	Projet 1000 Jeunes filles
IPC	NGO	Appui technique et financier aux associations de lutte contre le sida
Centre Muraz/ OCCGE	NGO	MST et VIH/SIDA chez les jeunes et dans la population générale de Bobo-Dioulasso
PROMACO	NGO	Projet de Marketing social du Condom
APJAD	Youth association	IEC en MST/SIDA et PF avec animateurs relais
AAS	Youth association	Activités d'IEC en MST/SIDA
APES	Youth association	Activités d'IEC en MST/SIDA et PF
CAMEROON		
PMSC	NGO	Horizon Jeunes
YDF	Youth association	Jeunes pour Jeunes
FESADE	NGO	Sexual Education of adolescents
OFSAD	NGO	Sexual education of adolescents in familial context

Table 2.1. Main non-governmental programs in ARH in Burkina Faso, Cameroon and Togo (continued)

Executing agencies (acronyms)	Organization type	Program name/title
CAMEROON (continued)		
SCS	NGO	Education à la vie et à l'amour (EVA)
CAMNAFAW	NGO	Programme d'IEC jeunes
Scouts of Cameroon	NGO	Mobilisation des jeunes en SRA
CASS	NGO	Éducation des Jeunes
Cameroonian Red Cross	NGO	Éducation à la parenté responsable
CSA	NGO	Formation des pairs conseillers
ALVF	NGO	Santé reproductive des femmes et des adolescentes
TOGO		
UNICEF	International organization	Programme Éducation de Base des Filles
Croix Rouge Togolaise	NGO	Programme SIDA et MST « Agir avec les Jeunes
Arc en ciel	NGO	Programme d'Éducation à la Prévention des MST/SIDA
Clubs UNESCO	Youth association	Programme Permanent d'Information, d'Éducation et de Communication en Santé Reproductive
ATBEF	NGO	Prise en charge des besoins des jeunes en santé sexuelle et de la reproduction

These non-governmental programs were analyzed and contrasted using the conceptual framework presented in Figure 1.1. Accordingly, the results are presented in six sections: program formulation, implementation plan, monitoring and evaluation plans, level of collaboration and coordination among programs and youth involvement.

2.1. Program formulation

Four aspects of program formulation are considered here: the program initiation, the definition of target groups and the reproductive health issues the programs address, and the formulation of the objectives.

2.1.1. Context of creation

Table 2.2 presents selected variables related to the initiation of ARH programs in each country: date of creation, development stage, whether the program is new or is a re-orientation of a preexisting program, and whether it is the result of an international initiative or not.

Table 2.2: Selected program characteristics by country (number of programs)

	Burkina Faso	Cameroon	Togo	Total
Year of creation (Median)	1994	1996	1996	1996
Development stage				
Beginning/start up	1	3	2	6
Execution	7	7	2	16
Maturity	0	1	1	2
New program (vs. Reorientation)	5	9	3	17
Part of a larger international program	4	4	3	11
Receiving financial support from international institutions	7	10	5	22
Number of programs analyzed	8	11	5	24

As seen in Table 2.2., while non-governmental programs in ARH have been created somewhat earlier in Burkina Faso (median year of creation 1994) than in Cameroon and Togo (median year of creation 1996), overall programs in ARH in the three countries have been designed recently. Without surprise, almost all of them are either at the beginning or execution stage and only two programs have reached maturity (the program

"Horizon Jeunes" in Cameroon that was a pilot project and the Program Club UNESCO in Togo that has started in 1987).

The majority of AHR programs in Burkina Faso, Cameroon and Togo are new programs rather than re-orientations of existing programs. Re-orientation of existing programs are either implemented by organizations or associations that have been active in youth-related activities or health activities for long and decided to focus on ARH (e.g. the Red Cross in Burkina Faso and Cameroon) or by organizations that were already active in ARH but decided to broaden their scope of activities (e.g. ATBEF in Togo).

Finally, we examined whether programs in the three countries are part of larger international initiatives. As seen in Table 2.2, about half (46 percent) of non-governmental programs are part of larger international programs. Some of these programs have been implemented directly by international institutions (e.g. the UNICEF program on girls education in Togo or the Population Council program in Burkina Faso) while others are managed by local organizations that are the local representatives of larger international institutions. Among the latter, one can cite the programs implemented by CAMNAFAW in Cameroon, ABBEF in Burkina Faso and ATBEF in Togo which are the local representatives of International Planned Parenthood Foundation (IPPF), the program Horizon Jeunes from PMSC, the Cameronian representative of Population Service International (PSI) and the program managed by IPC, the Burkinabé affiliate of Alliance International.

It is important to note, however, even when programs are not part of larger international initiatives, they generally receive international funding. In fact, the very large majority of programs (92 percent) are partly or totally financed by international agencies. The involvement of international donors goes often beyond simply financing programs and their inputs in the design and supervision of programs are often important. Thus, international agencies and international donors have played a crucial role in the formulation of non-governmental ARH programs in Burkina Faso, Cameroon and Togo, like it is the case in other parts of sub-Saharan Africa.

2.1.2. Target groups definition

We examined whether the RH programs in each country focus exclusively on adolescents and young adults or if they have defined adolescents as one of their targets. The large majority of programs analyzed (80 percent) focus exclusively on youth. For only five programs, activities targeted at youth are one of the components of the program: the program of ALVF in Cameroon, for instance, target women of reproductive age as well as adolescents, and the program PROMACO in Burkina Faso promotes condom use among the general public with a specific focus on adolescents.

We examined, like we did for governmental initiatives, whether target groups had been defined clearly (in precise terms) in the program documents and/or during interviews with program managers. Overall, the target groups were clearly defined in more than half (58%) of program documents. There are discrepancies across countries, however. While the majority of programs have given a clear and precise description of the adolescents and youth they targeted in Cameroon (9 programs over 11) and half of the programs in Burkina Faso did (4 programs over 8), target groups are poorly defined in Togo (only 1 program over 5). In many program documents or interviews with program managers, especially in Togo, generic and vague terms such as "youth" or "adolescents" are used to describe program beneficiaries. The characteristics of adolescents and young adults the ARH programs in Burkina Faso, Cameroon and Togo are trying to reach are shown in Table 2.3.

Table 2.3. Characteristics of youth targeted by programs, by country (number of programs)

	Burkina Faso	Cameroon	Togo	Total
Gender				
Females specifically	1	2	1	4
Males specifically	-	-	-	-
Both	7	9	4	20
Schooling status				
In school	2	2	1	5
Out of school	2	1	1	4
Both	4	8	3	15
Age				
10-19	-	3	1	4
10-24	-	2	1	3
Other age group	3	2	-	5
Not specified	5	2	3	10
Place of residence				
Urban	4	7	1	12
Rural	1	-	1	2
Both	3	4	3	11
Geographical scope				
National	2	3	1	6
Regional	-	1	3	4
Several cities or villages	2	-	-	2
One city/village	4	7	1	9
Number of programs analyzed	8	11	5	24

Table 2.3. shows that the majority of non-governmental ARH programs in the three countries (83 percent) have targeted both males and females. None of the programs target specifically male adolescents. Only one program in Burkina Faso (the program "*1000 jeunes filles*" of the Population Council) and one program in Togo (program created by UNICEF on basic education for girls) focus exclusively on female adolescents. Two programs in Cameroon (the programs from CASS and ALVF) give priority to girls, although they include boys and young men in their activities.

Similarly, the majority of programs in the three countries (62 percent) target both adolescents who are in-school and out of school. Programs focusing on out-of-school youth (such as the Red Cross program in Togo, the AAS program in Burkina Faso or the YDF program in Cameroon) are generally out-reach programs that do not exclude adolescents who are in school but conduct their activities outside schools.

As seen in Table 2.3., the majority of programs have not specified the age group they target or have provided some "unusual" age groups (outside the conventional "10-19 years old", or "10-24 years old"), especially in Burkina Faso and Togo. As mentioned above, several program documents in these countries remain vague in their definition and use generic terms to define their target groups without specifying any age group. In addition, age does not seem to be a selection criterion for the majority of programs. Programs that target youth at school, for instance, or those that reach adolescents through youth associations end up targeting adolescents from "non-conventional" age groups.

As far as geographical scope is concerned, there are differences across countries. In Togo, the majority of non-governmental ARH programs conduct their activities at the national or regional level. In Cameroon and Burkina Faso, program geographical scope is more narrow: in Cameroon 7 out of the 11 programs conduct their activities in one city (generally the capital city, Yaoundé) and in Burkina Faso six of the eight programs target youth in one or two cities or villages.

Considering the geographical scope of the programs, it is not surprising to see that priority is given to urban youth in the ARH programs conducted in Cameroon and in Burkina. Importantly, even when programs target both urban and rural youth, the large part of the activities often take place in the urban "headquarters". Only two programs specifically reach adolescents in rural areas. These are the programs that also focus of female adolescents: the program "*1000 jeunes filles*" from the Population Council in Burkina Faso and the UNICEF program on girls basic education in Togo.

Adolescents do not constitute an homogenous group and youth from various sub-groups (age or gender groups for instance) have different reproductive health needs that should be addressed differently (Hughes and McCauley 1998:239). We looked at whether or not programs in the three country have identified sub-groups of adolescents for their program activities and, if so, what their differentiation criteria were. Results show that, although the majority of programs target both males and females, adolescents in school and out-of

school and adolescents and young adults from various age groups, the majority of them (67 percent) do not differentiate their activities across sub-groups of youth they target. This is especially true in Burkina Faso where no program has identified sub-groups of adolescents and in Togo, where only two programs out of five did. In Cameroon, however, about half of the programs differentiate their activities according to sub-groups. Age is the differentiation criterion most often used. Importantly, the analysis of the documents shows that age is taken as a proxy for sexual activity and the distinction across age groups is, in fact, a distinction between adolescents who are sexually active and those who are not.

2.1.3. Reproductive Health issues addressed

During the Cairo conference, reproductive health issues were defined in a comprehensive manner. This included a wide range of issues concerning the consequences of unprotected sexual relations--unwanted or too-early pregnancy and childbirth, unsafe abortion, STDs and HIV/AIDS as well as sexual maturation, gender equity, sexual behavior and relationship and sexual abuse (United Nations 1994). Programs in ARH can be designed to answer one problem specifically or, in the alternative, to address a range of reproductive health issues. Few programs deal with all of the issues.

Table 2.4 shows the range of reproductive health issues addressed by non-governmental programs in Burkina Faso, Cameroon and Togo.

Table 2.4. RH issues addressed by programs in each country (number of programs)

	Burkina Faso	Cameroon	Togo	Total
Range of RH issues addressed				
One specific issue	4	-	1	5
Type of RH issues addressed				
STDs/AIDS	8	11	4	23
Unwanted pregnancies /abortion	4	11	4	18
Early pregnancies	2	11	3	16
Responsible parenthood	2	4	2	8
Genital mutilation, excision	1	2	1	4
Gender equity/sexual abuse	1	2	1	4
Number of programs analyzed	8	11	5	24

As seen Table 2.4., the majority of programs address more than one RH issue and only five programs focus on one specific issue. There are differences across countries, however. While no program in Cameroon and only one program in Togo focus on one specific RH issue, half of non-governmental programs (4 out of 8 programs) in Burkina

Faso do. These programs focus on STDs and AIDS prevention (the programs of AAS, IPC, PROMACO and Centre Muraz in Burkina Faso and the Togolese Red Cross program).

In the three countries the issue of STDs/AIDS is the RH problem most often addressed by programs (all programs but one). Undesired pregnancies and abortions (75 percent) as well as early pregnancies (67 percent) have also been defined as priorities by programs. Although the majority of programs target both males and females, responsible parenthood and gender equity appear not to be popular issues among programs. In fact, only four ARH programs have included gender equity or sexual abuse on their agenda. Similarly, although the reviews of adolescent reproductive needs in each country (see country reports) show that it is an acute problem in Burkina Faso, Togo and Cameroon, Female Genital Mutilation (FGM) is a topic neglected by programs in the three countries.

How were these programmatic priorities determined by program managers? Table 2.5 presents the various methods used by program managers or described in program documents to select which reproductive health issues to address.

Table 2.5. Methods used to define RH issues to address, by country (number of programs)

	Burkina	Cameroon	Togo	Total
Use of secondary survey data	-	6	1	9
Collect primary survey or focus group data	3	4	1	7
Informal feedback from the field (informal contacts with youth, discussions..)	2	4	1	7
Problems defined by international organizations (WHO, Cairo Conference ..)	2	1	4	8
Problems defined during national or regional forums, meetings	3	-	-	3
No method of definition mentioned	3	2	-	5
Number of programs analyzed	8	11	5	24

As seen in Table 2.5 the methods used by program managers to define the RH issues to be addressed vary from one country to the next. In Togo, programs managers have simply used the priorities expressed by international organizations, such as the World Health Organization (WHO), or during the Cairo conference. Only two programs also used secondary data (Club UNESCO) or primary data (Arc en Ciel) to define the reproductive health issues they will address.

In Cameroon, on the other hand, the majority of program managers have relied on results from existing surveys on adolescents reproductive health (6 programs over 11) and four programs have also collected their own data, conducting surveys or focus-group discussions among youth. Informal feedback from the field was used by four programs to define the RH issues they were going to address. Overall, very few program documents in Cameroon make reference to the Cairo conference or other international meetings and only one cites the ICPD as influential in defining their priorities.

In Burkina Faso, no program has relied on existing surveys to define the RH issues they address. Three programs have collected or plan to collect their own data, however. In 1996, for instance, the ABBEF conducted, in collaboration with the GTZ and the Population Council, a survey entitled *"Identification of adolescent specific needs in the area of sexual health*". This survey was used by both ABBEF and the Population Council to define the priorities of their programs. Other Program managers (three programs) have also used the priorities expressed by international organizations. The aspects the program in STDs/ AIDS prevention that the Centre Muraz deals with, for instance, are those defined by ONUSIDA. Similarly, the UNICEF program, initiated within the context of the UNPFA country program 1997-2000, follows the priorities of the UNFPA.

Finally, the three youth associations that have implemented STDs/AIDS prevention programs in Burkina Faso (APES, APJAD and AAS) have defined or redefined the orientation of their programs based on the results of the "National Forum on adolescent sexual and reproductive health in Burkina Faso" (" *Forum national sur la santé sexuelle et reproductive des adolescents au Burkina")* held in September 1997 in Burkina Faso. This forum, organized by the Ministry of Sport and Youth, and sponsored by UNFPA and the Population Council, brought together the 150 main youth associations of the country and has defined priorities in ARH to be addressed in the future.

2.1.4. Objectives formulation

A clear and precise definition of the program objectives is a key step in the program formulation process. In order to evaluate the program objectives as they were stated in the program documents or during interviews with program managers, we first classified them in two large categories: 1. Objectives whose results are easy to quantify and 2. Objectives that are linked to social processes, whose results are less easy to quantify and that need to be evaluated qualitatively (CIDA 1997). We then considered three characteristics of the objectives: 1. Whether the statement of the objective was clear and precise; 2. Whether the objectives are measurable and can be verified and 3. Whether deadlines for achieving the objectives have been set. The results of this evaluation are shown in Table 2.6.

Table 2.6. Evaluation of objectives (number of programs)

	Burkina Faso	Cameroon	Togo	Total
Objectives category				
Category 1	3	5	2	10
Category 2	5	6	3	14
Objectives are clear and precise	3	6	2	11
Objectives are measurable	2	5	2	9
Objectives include deadlines	2	5	2	9
Number or program analyzed	8	11	5	24

As seen in Table 2.6, in the three countries, for the majority of programs (58 percent) the objectives fall into the second category: those which results are not easy to quantify. Less then half of the programs have set objectives which results are easy to quantify.

Programs that have set quantifiable objectives are, for the very large majority, those whose objectives have also been formulated in clear and precise terms, that are measurable and include deadlines. Overall, very few programs (only 8 out of 24 programs) have objectives that meet all three evaluation criteria (not shown in the Table).

Too often, program objectives are formulated as long term goals, global missions such as “fight against STD/AIDS among youth”, or “promote IEC activities in ARH”. Formulation terms are often vague or too general such as “develop responsible sexual attitudes among youth” or “provide youth with correct and necessary information on SDTs/AIDS” or “develop self-promotion activities”.

Importantly, programs that are part of larger international initiatives or initiated by international institutions are, in general, more likely to have complete programs documents where long-term and short-term objectives, and deadlines are presented compared to programs that are not part of larger international programs.

The definition of target groups, reproductive health aspects to address, and objectives constitutes the first step in the program formulation cycle. The second phase is the elaboration of an implementation plan to achieve these objectives in adolescent reproductive health.

2.2. Implementation plan

To analyze the implementation plans of the non-governmental programs in the three countries, we looked at two important aspects of the program execution: the scope of activity considered, and the resources (human and financial) available.

2.2.1. Scope of activities

In all three countries, IEC is the dominant activity of ARH programs. As seen in Table 2.7, all programs in Cameroon and Togo include a IEC component, and 6 out of 8 programs in Burkina Faso do.

Table 2.7.: Main activities conducted by programs in each country (number of programs)

	Burkina Faso	Cameroon	Togo	Total
IEC activities	6	11	5	22
Peer educators	5	8	4	17
Information days/educational discussions	2	11	3	17
I.E.C. among parents, community leaders	-	7	2	9
Educational movies/radio shows/plays	5	7	2	14
Counseling	2	7	1	10
Production of I.E.C material	1	5	1	7
Family Life Education	-	3	3	5
Information center	1	5	2	8
Training	7	9	5	21
Peer educator training	6	8	3	17
Training of trainers	1	1	3	5
Training of other personal	1	1	-	2
Provision of RH Services	2	5	3	10
Clinics/health centers	1	3	1	5
Condoms distribution	2	2	2	6
Condoms sale	2	4	1	7
Institutional support	1	-	-	1
Research activities	1	1	-	2
Number of programs analyzed	8	11	5	24

Overall, peer education, educational discussions ("*causeries*") among youth, educational movies, plays or/and radio shows, are the most common IEC strategies implemented to reach youth in the three countries. In Cameroon, the majority of programs also include IEC activities among parents and/or community leaders (educational discussions, advocacy among community leaders, debates among parents and adolescents) and counseling activities (often cited in documents but rarely defined clearly). About half of programs produce of IEC materials (T shirts, caps, posters, or educational brochures or pamphlets) or run small information and counseling centers. In Burkina Faso, the range of IEC activities is more narrow and IEC activities consist, for the most part, of peer educator programs and educational movies, radio shows or plays. In Togo, FLE is part of the IEC activities of the majority of programs, in addition to peer educators and educational discussions.

Training is also a popular activity (88 percent of programs) in the three countries. As seen in Table 2.7, training activities mainly consists of training peers educators or "trainers" in (in Togo) for IEC activities.

If IEC activities are popular among ARH programs in Burkina Faso, Cameroon and Togo, fewer programs provide reproductive health services to youth (only 10 programs over 25). As seen in Table 2.7, the majority of programs that do offer RH services distribute or sale condoms to youth generally through their peer educators programs. Only 5 programs have opened or plan to open clinics or health centers for adolescents where RH services such as gynecologic exams, pregnancy tests, STD screening or contraceptives are provided. The three programs initiated by the local representatives of IPPF (the CAMNAFAW in Cameroon, the ABBEF in Burkina Faso and the ATBEF in Togo) have opened clinics or health centers providing RH services to youth. In Burkina Faso, the two Youth centers opened by the ABBEF in Ouagadougou and Bobo-Diollasso has been taken as a model for by the Government which is planning to expand the experience and build eight more youth center across the country (see Government Initiatives section 1.1.)

In addition, the ALVF in Cameroon plans to open such a clinic in Yaoundé and the program from OFSAD already has a small health center where a selected number of RH services are offered to youth in the capital city.

Finally, Table 2.7 shows that institutional support and operational research remain very marginal activities for ARH programs in the three countries (only one and three programs respectively). In fact, only the program initiated by IPC in Burkina Faso provides technical and financial support to youth organizations working in the area of STDs and AIDS. If seven programs have used primary data to define the RH problems they will address (see Table 2.5), these research activities are limited and only 2 NGOs (Centre Muraz in Burkina Faso and "Horizon Jeunes" in Cameroon) include a clear and developed operational research component and have used or plan to use research at

several points during their program to evaluate it. In both cases, the research activities are conducted by local research institutions that are partners in the programs.

2.2.2. Resource availability

Both structural, financial and human resources are considered here. Resources indicators are shown in Table 2.6. for each country. They include the implementation structures (existing versus new), the sources of funding (international agencies, government, other), the stability of the financial resources as perceived by program managers, and the perceived availability of human resources for program implementation.

Table 2.8: Resources indicators by country (number of programs)

	Burkina Faso	Cameroon	Togo	Total
Implementation structures				
Existing (versus new)	7	10	3	20
2				
Funding sources				
International	6	10	5	21
Government	1	-	-	1
Other	2	3	1	6
Perception of funding stability				
Stable	4	5	3	12
Perception of human resources availability				
Adequate (versus inadequate)	8	8	5	21
Number of programs analyzed	8	11	5	24

"To make the most of what exists" has been identified as one important programming principle for the design of successful sexual and reproductive health programs for young people (Hughes and McCauley, 1998). As seen in Table 2.8, the very large majority of NGO and associations in the three countries do follow that principle and use structures that were already in place to implement their ARH program. Only three programs have created new implementation structures.

As far as funding sources are concerned, as mentioned above, all programs but three are totally or partly funded by international agencies, which confirms the crucial role of international organizations in the creation of non-governmental ARH programs. UNFPA,

for instance, is a major source of international funding for non-governmental as well as governmental initiatives in ARH. One of the objectives of the UNFPA country programs in Cameroon (1998-2002), Burkina Faso (1997-2000) and Togo is to support programs promoting IEC and FLE, RH services, and youth centers. In fact, 3 programs out of 11 in Cameroon, 2 out of eight programs in Burkina Faso and 1 program in Togo are partly or totally funded by UNFPA. Other international organizations that have participated to the funding of the non-governmental programs in Burkina Faso, Cameroon and Togo include The World Bank (2 programs), USAID (2 programs), GTZ (4 programs), IPPF (3 programs), IWHC (1 program), UNICEF (2 programs) The Red Cross (2 programs), Alliance Internationale (1 program), or CARE International (2 programs), UNESCO (2 programs), and WHO (1 program).

Only one program, the program in STDs and AIDS prevention initiated by AAS in Burkina Faso, is partly funded by the government. Part of the budget comes from the PPLS (Programme Population et Lutte contre le Sida) which is funded with the government credit from the World Bank to fight against AIDS. Finally, other organizations, mainly small youth associations, also rely on fees collected among members, national donors (such as private companies) or benefits from small-scale business activities to finance their ARH programs.

As seen in Table 2.8, while the very large majority of program managers believe that the necessary human resources are available to implement their ARH program adequately, they are less unanimous regarding the stability of financial resources. In fact, only half of the programs managers interviewed believe that the funding sources for their programs are stable. Programs initiated by youth associations are more likely to encounter funding problems than programs initiated by larger ONGs. In fact, all the five youth associations leaders interviewed mentioned that the funding sources for the implementation of their programs were unstable. All the programs initiated by youth associations in the three countries rely on more than one source of funding but these funds are limited. In general, programs that are funded by one specific international organization are more likely to perceived as financially stable by their managers than programs that are not.

2.3. Monitoring and evaluation plan

To optimize program implementation, monitoring methods need to be clearly defined and planned. Three indicators are taken into account to evaluate the monitoring and evaluation plan: the monitoring methods selected, the existence of both concrete and pertinent performance indicators, the evaluation plan and scheme.

2.3.1 Monitoring methods

Table 2.9. shows the monitoring methods mentioned in program documents or by program managers during interviews. As seen in Table 2.9, all programs in Togo and

Cameroon include some monitoring methods, while only half of the programs in Burkina Faso do.

Table 2.9: Monitoring methods by country (number of programs)

	Burkina Faso	Cameroon	Togo	Total
Periodic visits to the field	1	8	1	10
Meetings	4	4	1	9
Periodic reports	4	5	5	13
No method mentioned	4	-	-	5
Total number of programs analyzed	9	11	5	24

Overall, the description of monitoring methods provided by managers or made in program documents was brief and vague in the three countries. Very few programs (e.g. the programs from ALVF and YDF in Cameroon) provided a clear and detailed description of monitoring plan including methods used, frequency, person responsible for the monitoring activities etc. As seen in Table 2.9, the most often cited monitoring methods in Cameroon are "periodic visits to the field" ("*descentes sur le terrain*") and "periodic reports" (activity reports from supervisors, coordinators, or peer educators). In Togo the implementation of all programs seems to be monitored through periodic reports, while in Burkina Faso reports and "meetings" are the methods most often cited by program managers.

2.3.2. Performance Indicators

Like the elaboration of program objectives, the existence of clear and concrete performance indicators is an important aspect of ARH program formulation. We examined whether such indicators were specified in program documents or were described by program managers, whether these indicators were concrete, and pertinent in relation to program objectives.

The results show (Table 2.10) that the large majority of program descriptions include some performance indicators (80 percent). An analysis of these indicators, however, reveals that they are not always pertinent in relation to program objectives. "Opening a new center for youth", for instance, is a concrete indicator but is not pertinent to measure the efficiency of a youth program. On the other hand, "the impact of the program on national indicators" or "the evolution of number of program participants" may be pertinent measures of program performance but are not precise enough measures to serve as a concrete indicator.

Table 2.10: Evaluation of performance indicators by country (number of programs)

	Burkina Faso	Cameroon	Togo	Total
Existence of indicators	7	7	5	19
Indicators are:				
Concrete	5	5	3	13
Pertinent	6	5	3	14
Concrete and pertinent	5	4	2	11
Number of programs analyzed	8	11	5	24

In fact, less than half of the programs include concrete and pertinent performance indicators. Without surprise, all programs that have set clear and precise objectives, including deadlines are also those that have defined concrete and pertinent performance indicators.

2.3.3. Evaluation Plan

Finally, we examined whether program descriptions given by program managers or as stated in program documents include an evaluation plan and if so, if programs had already been evaluated. For the majority of non-governmental programs in the three countries (70 percent) an evaluation is planned. As with the monitoring methods, however, few details were generally provided by program managers or in program documents regarding the content of the future evaluation and the evaluation mode.

Less than half of the programs (11 out of 24 programs) have already been evaluated. Since ARH programs are relatively new these evaluations took place recently (5 were evaluated in 1999, 5 in 1998 and one 1996). Program evaluations indicate either the end of a pilot program (e.g. the program of PMSC in Cameroon), the beginning of a new program phase (e.g. CASS program in Cameroon), a mid-term evaluation (e.g. PROMACO in Burkina Faso) or, in most cases, a more informal periodic evaluation (e.g. program Club UNESCO in Togo). Out of the 11 programs evaluated, three were evaluated internally, 4 programs used external evaluators (either an individual from the funding agency or independent consultants) and four programs used both internal and external evaluators.

2.4. Level of collaboration and coordination among programs

One of the objectives of the study is to evaluate the level and type of collaboration among non-governmental ARH programs and the level of collaboration and coordination of private and public efforts in the area of RH. In that perspective, we first examined the number of partners involved in each program and their role. We then looked at the level of coordination among non-governmental programs and among non-governmental and governmental programs.

2.4.1. Level and nature of collaboration

Table 2.11 shows the type of partners involved in non-governmental programs in Burkina Faso, Cameroon and Togo. As seen in Table 2.11, in each of the three countries several partners have been involved, or are still involved, in the formulation and implementation of non-governmental programs. In fact, all NGOs or youth associations in Burkina Faso and Togo have involved partners in their program and the majority of programs in Cameroon (8 programs out of 11) involve several partners. These partners include other local NGOs, government and ministries, youth associations and research institutes.

Table 2.11 : Type of partners involved in non-governmental programs, by country (number of programs)

	Burkina Faso	Cameroon	Togo	Total
Partner type				
Other local NGOs	5	6	4	15
International organizations other than funding agencies	4	2	-	6
Government/Ministries	8	4	4	16
Youth associations	4	6	-	10
Research institutes	3	1	1	5
No partner	-	3	-	3
Number of programs analyzed	8	11	5	24

As seen in Table 2.11, the level of collaboration among local NGOs and youth associations around ARH programs is relatively high in the three countries: (62.5 percent of programs involved several NGOs). The analysis of program documents and interviews transcripts reveal, however, that this high partnership among local NGOs remains limited in time and is rarely formal.

In Cameroon support received by other local NGOs is described by program managers as "exchange of expertise", "consultancy services", and, more often, as "provision of educational material". The program "Education des jeunes" of CASS, for instance, uses documents elaborated by FESADE and SCS. The NGO ACSA (like OFSAD) uses technical material created by the Scouts of Cameroon and "benefits sometimes from technical support from PMSC". The content of the training program on sexuality and gender put in place by ALVF has been elaborated in collaboration with the local association FESADE.

Similarly, in Togo the partnership among NGOs is described by the four program managers who cited some local partners as "technical support" or "support on the field" for specific activities. The association ATBEF, in particular, seems to play a critical role of technical support for other NGOs (the association has been cited by all other program managers).

In Burkina Faso, as seen in Table 2.11, the majority program managers (5 programs over 8) have cited some local NGOs as partners. The description of the role played by these local NGOs is either brief (such as "technical support"), or nonexistent. For some programs the generic term "local NGOs" are used to describe local partners with no organization name being specified.

International funding agencies often provide technical support to programs they finance, some NGOs and youth associations (six of them) also benefit from technical support from international institutions that are not their funding agencies. In Burkina Faso, for instance, the program of OCCGE in STDs/ HIV is financed by the UNFPA but receives technical and methodological support from l'ONUSIDA. The program of institutional support to associations in AIDS prevention from IPC is financed by Alliance International but is implemented in collaboration with Plan International. Similarly, the Cameroonian program from ACSA receives technical assistance from IAAH without being financed by the organization.

The government and its ministries, or more generically the "civil services", are also often cited as partners involved in the formulation and implementation of nongovernmental programs in the three countries. The level of partnership varies across country, however. In Burkina Faso all programs involve a partnership with the government, in Togo all programs but one do, while in Cameroon only four program managers have cited government as a partner.

In Togo, the program initiated by UNICEF on girl's education has been elaborated and is implemented in close collaboration with the Ministry of National Education and Scientific Research and the Ministry of Women Promotion. For the other three non-governmental programs, collaboration with the government is less formal and developed and consists mainly in occasionally putting structures or personnel ("*personnes*

resources") at the disposal of the program. For instance, the Ministry of Youth and Sport sent an instructor to the ATBEF Youth center in Lomé.

In Burkina Faso, where several non-governmental programs focus specifically on STDs and AIDS prevention (see section 2.1.3) the CNLS (Comité National de Lutte contre le SIDA) and the PPLS (Program Population and Lutte contre le Sida) are, without surprise, the governmental partners most often cited. The association AAS, for instance, has received technical support from the CNLS for the IEC training of its members. Other government bodies include the Ministry of Health, the Direction of Familial Health (Direction de la Santé Familiale), and the Ministry of Youth. While government ministries are cited by all program managers or in all program documents, their role and the nature of their partnership with the NGO is rarely specified, however, which makes the level of actual collaboration difficult to determine.

In Cameroon, less than half of non-governmental programs have governmental partners. When they do, the role of governmental partners are often described by managers and in vague terms such as "technical support", "administrative support", "support in personal and structures", or even "moral caution". Even if some programs, such as the program Horizon Jeunes from PMSC, have signed a draft agreement ("protocole d"accord") with the Ministry of Health before initiating their activities, the involvement of Ministry is low and often amount to the presence of an official from the government during public IEC events or ceremonies.

Overall, the involvement of youth associations in the formulation and implementation of ARH programs is relatively low. In Togo, no program collaborates formally with any youth association. In Burkina, only half of the programs include a youth association in their partner's list. The IPC program provides financial and technical support to Burkinabé youth associations. Youth organizations are its target groups as much as its partners. Other programs that include youth organizations as partners are programs implemented by youth associations themselves (AAS, APJAD, APES). Thus, the collaboration is in fact a collaboration among youth associations rather than a collaboration of NGO/youth associations. Again, the nature of this partnership is difficult to determine from the data available and since the roles played by the partners has not been specified during the interviews or in the program documents. In Cameroon, the involvement of youth organizations is slightly higher (6 programs over 11). Importantly, when they are cited, youth associations are either the target groups of the programs or places where personal are selected. The EVA program, for instance, target youth out of schools through youth organizations and the YDF program selects its peer educators among members of local youth associations.

Finally, Table 2.11 shows that local research institutes are not popular partners of non-governmental programs in the three countries. While some programs have used primary data collected among youth to define adolescent needs (see section 2.1.3), few of them have a local research institute as formal partner. In Cameroon, only the program Horizon

Jeunes from PMSC has a local research institute (IRESCO) as a partner that was in charge of the operational research component of the program. Similarly, in Togo, URD is involved with Tulane University in a youth study that will help evaluate the youth program of ATBEF. In Burkina Faso, the program of OCCGE in STDs/ HIV is also fully associated with UERD to conduct a baseline survey that will be used for the evaluation of the program. UERD was also cited as a research partner for the AAS and APJAD programs.

2.4.2. Collaboration and coordination among programs

In addition to the number of partners involved in each program and their role, we examined, and interviewed program managers on, the level of actual coordination among non-governmental programs and among non-governmental and governmental programs. Results show that the level of coordination vary across countries.

In Burkina Faso, important steps have been taken to increase the level of collaboration among ARH initiatives. Following a dissemination seminar of the results of an operational research effort on adolescent reproductive health organized by two research institutes (CERPOD and UERD) and the Burkinabé Midwives, a national network of youth associations working in ARH, the RENAJEP/SR (*Réseau National de la Jeunesse pour la Promotion de la Santé Sexuelle et Reproductive*), was created in 1997. Its action plan was finalized following the "National Forum on adolescent sexual and reproductive health in Burkina Faso" held in September 1997 (see section 2.1.3).

The main objectives of RENAJEP are to provide youth organizations with national, regional, and provincial coordination structures and with a national reference framework (the National Plan of Action in ARH) for all their ARH activities. The programs implemented by APJAD, APES, and AAS in STD/AIDS IEC (see Table 2.1.), for instance, are coordinated at the national, regional, provincial levels by RENAJEP.

Overall, five program managers out of the eight interviewed in Burkina Faso stated that there is a coordination of their programs with other non-governmental and/or governmental programs. Besides the three programs implemented by youth organizations members of RENAJEP mentioned above, the other two programs are those funded by UNFPA and initiated in the context of the UNPFA country program 1997-2000 (see results section 1). These programs (UNICEF and centre Muraz program) are coordinated with other governmental initiatives through the Direction of Familial Health (DSF). Importantly, for all five programs, no detail was provided on how this coordination among ARH initiatives actually takes place.

In Cameroon and Togo, the level of coordination among programs is significantly lower. In fact, although NGOs and youth associations that have implemented ARH programs know each other well and are collaborating informally, the results suggest that there is no coordination among programs in the two countries. Some program managers interviewed

in Togo have mentioned the existence of "an informal coordination" or of a "collaboration without real coordination".

The lack of formal collaboration among NGO in Cameroon had been already noted during a seminar of ARH advocacy that took place in Yaoundé in March 1999. Following this seminar, a network of NGOs and associations working in the area of health, ROSACAM, was created in May 1999. The objectives of ROSACAM, as stated in the official registration documents, is to "create a framework of collaboration and dialogue for the integration of its members", "elaborate some minimal common programs of action", "facilitate the connection of members with national international organizations working in the area of health". Although ROSACAM does not focus on NGOs working in ARH, it represents a promising attempt to increase collaboration among ARH programs in Cameroon.

In the same vein, a legal framework of collaboration between the Ministry of Health and the associations and NGOs working in the domain of health was elaborated and ratified by a ministerial decision on April 14, 1999. With this decision, each association that wants to collaborate with the Ministry of Health and benefit from the support of national health structures can be registered officially. Once registered, the association needs to elaborate projects annually in collaboration with the Ministry and produce annual activities reports.

2.5. Level of youth involvement

Several studies have stressed the crucial role of youth involvement when developing and evaluating programs and policies (Senderowitz 1995; Hughes and McCauley 1998). Thus, we have assessed the level and nature of youth involvement at each stage of the program design process (formulation, implementation plan, evaluation and monitoring plan). In assessing the level and nature of youth involvement, distinction was made between direct and indirect mode of involvement. Examples of indirect youth involvement include surveys or focus groups conducted among target groups at the program formulation stage, or informal feedback from the field. Formal consultations with youth group representatives, or structured surveys conducted among "programs users" at the evaluation stage are examples of direct involvement.

Results show that the majority of program managers (72 percent) in the three countries declared having involved youth when identifying the reproductive health issues to be addressed by their programs and defining program objectives. The analysis of the interviews and program documents shows that, overall, this involvement remains very indirect. In Cameroon and Togo, programs that have involved youth at the formulation stage (8 over 11 and 3 over 5 respectively) have done it indirectly through qualitative or quantitative surveys conducted among target groups, informal feedback from the field, or, most of the time, by using existing surveys conducted among youth (see results section 2.1.3).

In Burkina Faso, where six program managers out eight declared having involved youth at the formulation stage, the implication is more direct. First, more programs are run by youth associations in Burkina Faso than in Cameroon and Togo. Second, as mentioned above, several national manifestations such as the "National Forum on adolescent reproductive health" or the "national week for the dissemination of results of research of sexual and reproductive Health" (see results section 2.1.3) have helped define national priorities in RH and have made the involvement of youth representatives in program formulation somewhat more direct.

As far as youth involvement in the program evaluation is concerned, only four out of the 11 programs that have already been evaluated have involved youth in their evaluation. For these four programs, the involvement of youth in the evaluation consisted of either a "post intervention survey" conducted among "programs users" (2 programs), informal feedback from the field (1 program), or in the presence of youth representatives on the evaluation team (1 program).

Finally, we asked the 5 youth organizations that have implemented an ARH program in the three countries if they had been asked by other organizations to help program managers at the formulation, implementation or evaluation stage of their program. All five representatives of youth associations answered that their associations had been solicited. This involvement, however, consisted mainly of participating in meetings and forums (such as the National Forum in Adolescent reproductive Health in Burkina Faso or the World Forum of Youth (*Forum Mondial de la Jeunesse*) in Vienna in 1995) or in informal collaboration for the implementation of specific events (see section on Level and nature of collaboration).

VI. CONCLUSIONS

The present evaluation of the policy and programs initiatives on adolescent reproductive health in Burkina Faso, Cameroon and Togo have revealed strengths and best practices as well as weaknesses and obstacles.

1. ACHIEVEMENTS AND BEST PRACTICES

- The review of governmental initiatives in the area of ARH in Burkina Faso, Cameroon and Togo shows that, since the ICPD 1994, adolescents and young adults have been recognized as a specific target group within national policies and programs.

- The political will to address the specific RH needs of adolescents and young adults is exemplified in the revised population policies, the new orientation of the national health policies, the national programs to combat AIDS, the strengthened FLE programs, the initiatives to eliminate FGM and the creation of youth health units within the Health Ministries.

- Specific national youth health programs are being elaborated in Cameroon and Burkina Faso and one has already been adopted in Togo. The programs and policies that exist have recognized several important RH issues affecting youth. These include such matters as early pregnancies, unwanted pregnancies, induced abortion, STDs/AIDS and FGM. The lack of adequate health services to satisfy the RH needs of youth and the difficult access to traditional health services are also underlined in the documents.

- The scope of RH activities planned by the (future) program/policy in national youth health programs and policies is broad and includes a wide range of both IEC activities and provision of RH services.

- The need to take into account the fact that adolescents do not compose an homogeneous group when designing RH activities targeted at youth has been recognized by national youth health programs in Togo and Cameroon. The importance of involving youth in the design, implementation and evaluation of national youth programs has been acknowledged in the three programs.

- Research activities as well as the revision and diffusion of legal texts relating to ARH are important policy endeavors. These are included in the list of activities recommended by national youth health programs in the three countries.

- The need to increase and improve the level of coordination and collaboration among private and public actors in RH and among various levels of the Ministries have been recognized by the three national programs for youth health and is include as a primary objectives of these programs.

- NGO and youth associations have been active in the promotion of adolescent reproductive health and several non-governmental programs in ARH have been elaborated in Burkina Faso, Cameroon and Togo.

- Overall, the majority of non-governmental programs have targeted the adolescent and young population at large and both girls and boys, youth in school and out-of-school, adolescents and young adults as the beneficiaries of program activities.

- Half of the non-governmental programs elaborated in Cameroon have recognized that adolescents do not constitute an homogenous group and that youth from various age groups (as a proxy for sexual activity) have different reproductive health needs that should be addressed differently.

- Non-governmental programs have addressed reproductive health issues that the existing research body (see country reports) have shown as acute among Cameroonian, Togolese and Burkinabé adolescents: STDs,/AIDS, undesired pregnancies and abortion, and early childbearing.

- All non-governmental programs have a IEC component and the scope of IEC activities is large, increasing the chance to effectively reach the adolescent and youth population.

- The large majority of NGO and associations in the three countries "make the most of what exists" and use structures that are already in place to implement their ARH program.

- The large majority of managers of non-governmental programs believe that the necessary human resources are available to implement their ARH program adequately.

- In the three countries, the level of informal collaboration among local NGOs is relatively high. The creation of NGO and association networks such as ROSACAM in Cameroon and RENAJEP in Burkina Faso are examples of promising initiatives to increase and formalize the level of collaboration among ARH initiatives.

2. WEAKNESSES AND OBSTACLES

- The development and adoption of policy and program documents reflecting the ICPD Agenda on ARH and the definition of clear national guidelines in the domain has been slow, especially in Cameroon. The Cameroonian DNPP has not been revised to provide general guidelines in ARH, most of the new national health and educational policies have not been adopted and/or are not fully developed, and the national youth health policy is still a draft. Even in Burkina Faso, where the government has been the most dynamic in formulating new policy and program documents reflecting the ICPD Agenda on ARH, several important documents, including the National Youth Health program, have not been officially ratified yet.

- In Togo, the concept of ARH is absent from the 1998 NPP, where early childbearing is the only ARH issue identified and the provision of ARH services amounts only to promotion of EPD among youth. Thus, the 1998 NPP, which is a reference document for policy development, is not congruent with the orientations in ARH expressed in the Reproductive Health Policy and Standards and the National Youth Health Program.

- The orientation of the Cameroonian government with respect to ARH, as presented in the DNPP, the MCH/PH policy, and the National Plan to Combat AIDS, emphasize IEC activities and FLE and there seems to be a reluctance to address the issue of adolescent access to RH services including contraception.

- In Cameroon, the PANEM has not been adopted yet and no action has been taken to make FGM illegal. On the other hand, in Togo, while the law against FGM is an important step in the battle against female excision, no preventive program has been elaborated.

- Gender equality, which is an overriding and basic principle behind the Cairo Agenda and behind the concept of RH, is not emphasized strongly enough in the content of activities planned by the national youth health program directed at youth and gender is not taken into account in the definition of target groups.

- Lack of adequate funding seems to be an obstacle to the implementation of the PNSJA in Togo. Only few of the activities planned have started.

- While the importance of involving youth in the design, implementation and evaluation of national youth programs has been acknowledged in the three programs, the mode of achieving youth involvement is not clearly described.

- While the need for coordination of public efforts across various ministries or across different sections of a same ministry is stressed in all three program/policy documents, the lack of reference to other policies or programs in these documents is striking and suggests that the actual definition and level of coordination needs to be improved.

- Despite the initiation of several non-governmental programs in adolescent reproductive health in the three countries, their geographical impact remains limited, especially in Burkina Faso and Cameroon. In both countries, the majority of non-governmental programs concentrate their activities in one or two cities or villages, or even in a selected neighborhood of the one city (generally the capital city). Few programs have implemented activities at the national level. Overall, rural adolescents are neglected and youth living in urban areas are the priority beneficiaries of non-governmental programs.

- The target groups are ill-defined by managers of non-governmental programs or in program documents in Burkina Faso and Togo. Adolescents seem to be considered as an homogenous group and very few programs in these two countries have defined sub-groups of adolescents and designed specific activities for these sub-groups.

- In the range of reproductive health issues addressed by non-governmental programs, where priority is given to important issues such as STDs/AIDs and early/undesired pregnancies prevention, problems such as gender issues, female genital mutilation, or lack of responsible parenthood, which are also acute social and cultural problems youth are facing in the three countries, are rarely addressed.

- The formulation of reproductive health issues addressed by non-governmental programs has not relied enough on primary or secondary data on adolescent reproductive needs, especially in Togo and Burkina Faso. Overall, the links between non-governmental programs and local research institutes are weak in the three countries and very few programs include in their activities a clear operation research component or have established a formal partnership with local research institutes.

- In the three countries, the objectives of non-governmental programs are too often formulated as long terms goals or global missions. Formulation terms are often vague or too general and few non-governmental programs, generally only those that are part of larger international initiatives, have set specific and clear objectives, that are measurable and include deadlines.

- IEC is the dominant activity of non-governmental programs in Burkina Faso, Cameroon and Togo. The provision of reproductive health services is an aspect neglected by programs and, where it does exist, it generally amounts to the

distribution of free or subsidized condoms. Only five programs have opened, or plan to open, generally in cities, clinics or health centers for adolescents.

- Despite the crucial role played by international agencies in the funding of non-governmental programs, only half of program managers interviewed in the three countries believe that their funding sources are stable and adequate for the continued implementation their programs. Additionally, the important dependency of local programs on international funding places in question their durability.

- As far as monitoring and evaluation are concerned, the results show that the description of monitoring methods for program implementation are often none-existent (e.g. Burkina Faso) or rudimentary. Less than half of program descriptions include concrete and pertinent performance indicators and, if for the majority of non-governmental programs an evaluation is planned, few details are provided on the content and the nature of this future evaluation.

- Despite a high level of informal collaboration among NGOs working in the ARH sector in Cameroon and Togo and the newly created ROSACAM in Cameroon, the actual coordination among non-governmental ARH programs in the two countries remains very low. In Burkina Faso, thanks to the presence RENAJEP, the level of coordination among non-governmental programs seems higher, although few details have been provided regarding the coordination mechanisms.

- The picture of collaboration between the public and private sector in the domain of ARH looks the same. The level of "declared" collaboration is relatively high, especially in Burkina Faso and Togo, but the actual coordination is low (Cameroon and Togo) or vague (Burkina Faso).

- Although the majority of managers of non-governmental programs in the three countries declared having involved youth at the formulation stage, this involvement remains very indirect, especially in Cameroon and Togo. Youth involvement in the program evaluation is also low.

- Local youth organizations that have been solicited by other organizations working in ARH to participate were called upon mainly to attend to meetings and forums or for the implementation of limited specific events.

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